Elite Homecare Services

CLIENTS QUESTIONNAIRE

1. CLIENT BIODATA

Full Name : ____

Date of Birth : --/--/----

Address : ____

Phone Number : ____

Email Address : ____

Emergency Contact Information: ____

2. HEALTH AND MEDICAL INFORMATION

Medical Conditions

- Current Medical Diagnoses : ____-

- Chronic illnesses: ____

- Recent surgeries or hospitalizations:____

- **Medications**

- List of current medications: ____

- Dosage and administration times: ____

- **Allergies**

- Food allergies: ____

- Medication allergies: ____

- Physical Abilities and Limitations: ____

- Mobility status (walking, wheelchair, bedridden): ____

- Assistance needed with activities of daily living (ADLs) such as bathing, dressing, eating, etc.:

____

- Cognitive Status: ____

  - Any memory issues or cognitive impairments (e.g., dementia, Alzheimer's) : ___________________

3. Care Needs and Preferences:

- Type of Care Required: ____

  - Personal care (bathing, grooming): ____

  - Medical care (wound care, medication management): ________________________________

  - Companionship: ____

  - Housekeeping and meal preparation: ____

- Frequency and Duration of Care :

  - Number of hours per day/week: ____

  - Preferred schedule (specific days/times): ____

- Special Requirements: ____

  - Language preferences : ____

  - Religious or cultural considerations: ____

4. HOME ENVIRONMENT

- Living Situation: ____

  - Living alone or with family/others: ____

  - Type of residence (house, apartment, assisted living): ______________________________________

- Home Setup:

  - Accessibility features (ramps, grab bars) : ___________________________

  - Any special equipment needed (hospital bed, lift, etc.): _______________________

5. FINANCIAL INFORMATION

- Payment Method:

  - Private pay: ( )

  - Insurance (Medicare, Medicaid, private insurance): ( )

  - Long-term care insurance: ( )

- Budget:

  - Client's budget for home care services: ____

- Billing Preferences:

  - Monthly, weekly, bi-weekly: ____

6. PREVIOUS HOME CARE EXPERIENCE

- Previous Care Providers:

  - Any previous home care services used: ____

  - Reasons for discontinuation if applicable: ____

- Feedback and Preferences: ____

  - What worked well or didn't work with previous providers:

____

- Preferred Method of Communication (phone, email, in-person) : ________________________________

8. ADDITIONAL INFORMATION

- Referral Source:

  - How did you hear about our services? ____

  - Any other relevant information or specific requests: ____