noela inc.

SERVICE IN-TAKE FORM

Date: ____________ Services: COMP

Name of Individual: ______________________ DOB: ____________________

Gender: __________________ Marital Status: ______________ Race: _______

Referred by: ______________________ Disability: ________________________________

Individual is: ___ competent **X** incompetent. If incompetent, documentation present: ___Yes __No

Legal guardian (if applicable): __________________________

Relationship to Individual: ______________________

Address: ____

Telephone number: ____

Diet: ____

Allergies to any medications: ____

Other allergies: ____

Special Equipment (cane, wheelchair etc.): ____

Strengths: ____

Needs: ____

Likes: ____

Dislikes: ____

Describe any concerns the individual has: ____

____

Describe the individual's personal life goals, visions, and dreams: _______________________________

____

Medications: ____

____

List all current medical conditions: ____

Any ongoing medical care needed: ____

Any ongoing lab testing needed: ____

Physician: ______________________________ Telephone Number: ____________________

Psychiatrist: ____________________________ Telephone Number: ___________________

Dentist: ________________________________ Telephone Number: ____________________

Other doctors:
Name: _________________________________ Telephone Number: ____________________

Name: _________________________________ Telephone Number: ____________________

Name: _________________________________ Telephone Number: ____________________

Social History:

Family History:

Collateral history from family or persons significant to the individual if available:
(Information about the individual may not be shared with the person giving the collateral history unless the individual has given specific written consent)

AGENCY USE ONLY

Document the result of the intake/assessment as to whether or not the agency can serve the individual.

It is the policy of the agency to give each individual a two-week trial period.

Please have the Individual or legal guardian (if applicable) initial the following:

I have received a copy of the Individual Rights and Responsibilities. _______________

I have received a copy of the Grievance Policy / procedure. ________________

____
Individual / Responsible Party Signature

Tal. Office Assistant_________
Agency Staff Signature/Position