COUNTRYSIDE CARE CO.
"Rooted in care. Built on community."

Countryside Care Co. Client Intake & Health Information

This form collects information necessary to provide safe, appropriate, and personalized home care services. Information is handled in accordance with PHIPA and Countryside Care Co.'s Privacy Policy.

1. Client Information

Client Full Name: _____

Preferred Name: _____

Date of Birth: _____

Gender (optional): _____

Address (service location):

_____

Primary Phone: _____

Email: _____

2. Primary Contact / Legal Representative (if applicable)

☐ Client ☐ Power of Attorney ☐ Substitute Decision Maker ☐ Family Member

Name: _____

Relationship to Client: _____

Phone: _____

Email: _____

☐ Legal authority documentation on file (if applicable)

3. Emergency Contact

Name: _____

Relationship: _____

Phone: _____

4. Physician / Health Care Provider (optional)

(For emergency or coordination purposes only)

Name: _____

Clinic / Practice: _____

Phone: _____

5. Health Information (Relevant to Non-Medical Care)

☐ This information is complete and accurate to the best of my knowledge

Known medical conditions (relevant to care):
☐ Dementia / Cognitive impairment
☐ Mobility limitations
☐ Stroke history
☐ Parkinson's
☐ Diabetes

☐ Heart condition
☐ Respiratory condition
☐ Mental health concerns (non-clinical)
☐ Other:

Allergies (food, medication, environmental):
☐ None known
☐ Yes (please specify):

---

6. Mobility & Transfers

☐ Independent
☐ Requires supervision
☐ Requires physical assistance
☐ Uses mobility aid (walker, cane, wheelchair, etc.)

Transfers:
☐ Independent
☐ One-person assist
☐ Requires equipment
☐ Not appropriate for staff assistance

7. Cognitive Status

☐ Alert & oriented
☐ Mild memory concerns
☐ Diagnosed dementia
☐ Requires redirection or supervision
☐ Sundowning / confusion at times

Safety concerns (if any):

---

8. Medication Information (Non-Medical)

☐ Client self-manages medications
☐ Requires reminders only
☐ Uses blister packs / prepared doses

Important note: Countryside Care Co. staff do not administer medications.

9. Personal Care Needs

☐ Bathing / hygiene
☐ Dressing
☐ Toileting
☐ Incontinence support
☐ Grooming / oral care
☐ Bed mobility / repositioning

10. Home Environment & Safety

☐ Home is generally safe and accessible
☐ Stairs present

☐ Pets in home (species/type): _____
☐ Smoking or vaping occurs in home
☐ Oxygen or medical equipment present

Any known hazards or concerns:

_____

11. Infection Control

☐ No current illness
☐ Recent illness (flu, COVID-19, etc.)
☐ Requires additional PPE

Please notify the agency of any changes.

12. Preferences & Personal Notes

(Helps us provide person-centred care)

Daily routines, likes/dislikes, cultural or religious considerations:

_____

_____

_____

13. Services Requested

☐ Non-medical home support
☐ Companionship
☐ Dementia support
☐ Respite care
☐ PSW-level care (subject to availability)
☐ Overnight care

14. Consent & Acknowledgement

By signing below, I confirm that:

- The information provided is accurate and complete
- I understand this form is used to develop the Care Plan
- I agree to notify Countryside Care Co. of any changes in health, mobility, or safety
- I understand services are non-medical and subject to scope and safety policies

Client / Representative Name: _____

Signature: _____ Date: _____