north shore senior center

www.nssc.org

house of welcome adult day services *specialized programs for people with memory loss*

Demographics/Health History		
Application date:		
Person completing application:	Relationship:	
Participant Demographics		
Participant name:	Preferred name/nickname:	
Address:	Date of birth:	
City/State/Zip:	Primary phone:	
Participant gender (x): ☐Female ☐Male ☐Non-Binary ☐Transgender-Female ☐Transgender-Male Other: _____ ☐Not Disclosed		
Participant living arrangement (x): ☐Alone ☐Spouse ☐Adult child(ren) ☐Caregiver Other (specify) _____		
Race (*chose up to two*) (x): ☐Asian ☐Black/African American ☐Hawaiian/Pacific Islander ☐Native American/Alaskan ☐White		
Ethnicity (x): ☐Hispanic/Latino ☐Not Hispanic/Latino		
Primary language spoken:	Other language(s) spoken:	
Driving status (x): ☐Still driving ☐No longer drives ☐Never drove		
Spouse/Partner (if any)		
Name:	Relationship:	Years together:
Address:	Occupation:	Retired (Y/N):
City/State/Zip:	Primary phone:	
Email:	Secondary phone:	
Primary Caregiver Information (if not spouse/partner)		
Name:	Relationship:	
Address:	Primary phone:	
City/State/Zip:	Secondary phone:	
Email:		
Other Emergency Contacts (local)		
Name:	Name:	
Relationship:	Relationship:	
Address:	Address:	
City/State/Zip:	City/State/Zip:	
Primary phone:	Primary phone:	
Secondary phone:	Secondary phone:	
Email:	Email:	

Advance Directives	
Does applicant have any of the following:	
Power of Attorney for Health Care (Y/N):	Power of Attorney for Property (Y/N):
Name:	Name:
Relationship:	Relationship:
Address:	Address:
City/State/Zip:	City/State/Zip:
Primary phone:	Primary phone:
Secondary phone:	Secondary phone:
Email:	Email:
POLST (Practitioner Order for Life-Sustaining Treatment form) or DNR (Do Not Resuscitate Order) (Y/N):	

Health Insurance Information		
Social security number:	Medicare number:	Part: ☐A ☐B ☐D
Name of any additional health insurance providers:		
Address/City/State/Zip:	Phone:	
Long-term care insurance (Y/N):	If yes, Carrier:	

Primary Care Physician Information	
Primary Care Physician:	Hospital system affiliation:
Phone Number:	Date of last appointment:

Specialist Information	
Physician name:	**Physician name:**
Specialty:	Specialty:
Hospital system affiliation:	Hospital system affiliation:
Phone:	Phone:
Physician name:	**Physician name:**
Specialty:	Specialty:
Hospital system affiliation:	Hospital system affiliation:
Phone:	Phone:

Medical Information	
Preferred hospital:	
Last hospitalization and reason:	
Memory	
When did you first notice memory problem?	
Date of diagnosis, if any:	Cause/diagnosis for memory loss:
Person's understanding of diagnosis:	
Please describe any significant changes in person's memory, language skills and behavior:	

Medications
(prescription and over-the-counter, including vitamins and supplements)

Name	Dosage (mg/frequency taken)	Reason for taking

Functional Information

Hearing

Hearing Loss (x):	Hearing Aids (x):	Comments:
☐ Right ear	☐ Right ear	
☐ Left ear	☐ Left ear	
☐ Both ears	☐ Both ears	
☐ None	☐ None	

Vision

Vision Loss (x):	Comments:
☐ Right eye	
☐ Left eye	
☐ Both eyes	
☐ None	
☐ Glasses/contact lenses	

Mobility

Walks independently (Y/N): ☐ Needs assistance with walking/transferring (Y/N): ☐ Uses assistive equipment (x):	Comments:
☐ Cane	
☐ Walker	
☐ Wheelchair	
☐ None	

Toileting (x)

	Comments:
☐ Independent	
☐ Needs some assistance	
☐ Needs complete assistance	
☐ Incontinent of urine	
☐ Incontinent of bowel	
☐ Uses incontinence products	

Allergies/Dietary

Please list all allergies (food, medication, animal, and/or environmental) and a description of the person's reaction:

Please list any dietary restrictions:

Other Significant Information

Please share anything else you would like us to know, including trauma, significant losses, family dynamics, etc.: