GOLDEN VISIONS
CLIENT PROFILE

Client Name: _____

Birthdate_____**Enrollment Date**_____**Social Security#**_____

Address_____

Phone number_____ Alternative number_____

Emergency Contacts

1st Contact Name _____Relationship_____

Address_____

Phone_____ Alt.Phone_____

2nd Contact Name_____Relationship_____

Address_____

Phone_____Alt. Phone_____

Ambulance transportation _____Preferred Hospital _____

I agree that the above emergency information is correct:

_____

Print **Signature** **Date**

Primary Physician_____

Phone _____Fax_____

Physician Address_____

Other Physicians or Specialists
Name_____Phone _____

Name_____Phone _____

Current Diagnosis_____
_____

Special Diet/Restrictions_____

Allergies/Sensitivities (Food or Medication)_____

Race _____Height _____ Weight _____ Hair _____Eye _____

Other identifying characteristics _____

GOLDEN VISIONS
CLIENT PROFILE

Medicare#_____Medicaid#_____

Secondary Insurance_____

Group Number _____ I.D. #_____

VA # _____

Served in Armed Forces/Branch? _____Where/When_____

SUPPORT SYSTEM Referred by _____

Agency involvement _____Case Manager _____

Power of Attorney_____Copy received and put in client record ____ Yes

Caregiver Needs or Limitations_____

_____

Other sources of support _____

AT HOME Lives in a: house_____ apartment_____ trailer_____

Language spoken and understood: _____Primary language spoken at home: _____

Usual means of transportation_____

Sleeping habits_____

Recent life events and effects_____

_____

Religious Affiliation (if you choose to divulge) _____

Single ____Married____ (date_____) Widowed _____(date_____)

Spouse(s) Name_____

Children's Names _____

GOLDEN VISIONS
CLIENT PROFILE

Client Name: _____

SOCIAL HISTORY

Current or former occupation(s) _____

Where did you live throughout your life?

_____

Hobbies/activities_____

COGNTIVE FUNCTIONING

Able to understand directions: ___ Yes ___ No
Able to communicate needs: ___ Yes ___ No
Aware of dangers, risks and consequences: ___ Yes ___ No
Has a need for supervision: ___ Yes ___ No

EMOTIONAL / BEHAVIORAL STATUS

Any Recent Stressful Events:

_____

How client responds to illness:

_____
_____

Emotional Strengths, expectations and motivations:

_____
_____

Any emotional problems or related behaviors such as wandering, sleeplessness, cursing, yelling, spitting or relieving self in inappropriate areas:

_____
_____
_____

Completed by_____date_____

GOLDEN VISIONS
MEDICAL FORM

(to be completed by the physician, CRNP or PA 90 days prior to enrollment and annually thereafter)

CLIENT NAME _____
Address _____
Phone _____

MEDICAL INFORMATION

Diagnosis: Primary: _____

Secondary: _____

Physical Disabilities/Limitations/Therapy Needs _____

Ability to participate in exercise program _____

Current orientation, cognitive abilities or mental health _____

_____

Most recent Cognitive Score (MMSE etc. if completed) _____

Ability to follow instructions: _____

Capable of understanding rights, plan of care? Yes _____ No _____
Capable of self-administration of medications? Yes _____ No _____

Medication

Medications presently taking	For	Dosage	Schedule
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

My patient may take Tylenol as needed for pain Yes _____ No _____

Tylenol 500 mg each 1 or 2 tabs P.O._____ q4H PRN pain _____
q6H PRN pain _____

Please return to:
GOLDEN VISIONS ADULT DAY SERVICES
250 Fame Ave., Suite 125
Hanover, PA 17331
Phone: 717-633-5072
Fax: 717-633-5064

GOLDEN VISIONS
MEDICAL FORM

(to be completed by the physician CRNP or PA 90 days
prior to enrollment and annually thereafter)

Client can self-administer the following from the listing: _____
_____

Known allergies _____

Diet _____ Any restrictions/special order: _____

I verify that this patient if free from communicable disease. Yes _____ No _____

Special instructions if patient has a communicable disease but may attend the adult day center:
_____

TB skin test results _____ Date administered _____ By whom/title _____
Date read _____ By whom/title _____
(must be read by RN or MD)
(must have negative results within 2 years of enrollment and every 2 years thereafter – per state regulation)

If TB Skin test is positive: The results of a chest X-Ray _____ date taken.

Medical Treatments: _____

Psychological Status/Problems: _____

General sensory functioning / sensory aides: _____

I have thoroughly examined _____on_____
and find that he/she is not in need of hospital care, does not require bed rest during the day and is, therefore,

able to participate in the GOLDEN VISIONS Adult Day Service Center.

Examiner's Signature / Title _____ Date _____

Name (print) _____

Address _____ Phone _____

12/2014

Please return to:
GOLDEN VISIONS ADULT DAY SERVICES
250 Fame Ave., Suite 125
Hanover, PA 17331
Phone: 717-633-5072
Fax: 717-633-5064

GOLDEN VISIONS
LIFE HISTORY

(This is for the family/responsible party to fill out and return)

Client's Name:_____ Date of Enrollment:_____

INTERESTS / PREFERENCES

Is the client awake: morning _____ afternoon _____ evening _____

At present, does the client:

____follow simple directions

____follow detailed directives (more than 3)

____feel comfortable in a large (more than 10) group

____prefer small groups (less than 10)

____participate in conversations

____participate in discussion while in group

____prefer to be isolated

____lead discussion groups

____prefer independent leisure pursuits such as _____

Other comments: _____

_____

PRIOR TO ENROLLMENT

What was the client's environment and daily routine?

_____

_____

_____

Has there been a change in the client's participation in daily activities?

_____

_____

_____

IN PAST 5 YEARS

What significant life experiences have stopped (cessation of driving, inability to participate in favorite social/physical events):

_____

_____

_____

_____

GOLDEN VISIONS
LIFE HISTORY

(This is for the family/responsible party to fill out and return)

LIFE EXPERIENCES:

HERITAGE (early life)

Birthdate _____ Birthplace _____

Grew up: _____

Family Names: Mother: _____ Father: _____

Sisters: _____

Brothers: _____

Other Significant Family Members: _____

Relationship with family members while growing up: _____

Family vacations and recreational activities: _____

_____

_____

Family anecdotes or interesting stories: _____

_____

_____

Any significant changes in the family(siblings, parents, grandparents, etc) relationship from childhood:

_____

_____

Any nicknames or childhood stories: _____

_____

LIFE EVENTS:

Educational Events: Highest levels achieved: _____

Where: _____ Awards: _____

Extracurricular Activities: _____

_____

Employment events: Occupation(s): _____

Employed Where: _____

GOLDEN VISIONS
LIFE HISTORY

(This is for the family/responsible party to fill out and return)

Client's Name:_____

Retired when: _____ After retirement employment: _____

When did that stop: _____

Military experience: Veteran:____ Branch of Service: _____ Years of Service:_____

Stationed where: _____

War Memories: _____

Any honors: _____

Marital Status: never married ___ Married ___ Date of marriage _____ to whom _____

Widowed ___ Date of death of spouse _____

Divorced ___ Date remarried _____ to whom _____

Relationship with spouse(s): _____

_____

Family dynamics: family decision maker, family caregiver: _____

Parental Status: # children ____ Names: _____

_____

Relationship with children while growing up and adults: _____

_____

Grand and Great-grandchildren: _____

_____

Other significant people: _____

OTHER SIGNIFICANT EXPERIENCES AND INTERESTS

Involvement in clubs and community organizations: _____

_____

within past 5 years:_____

within past 6 months: _____

Interest in literature or reading: _____

within last 6 months: _____

GOLDEN VISIONS
LIFE HISTORY

(This is for the family/responsible party to fill out and return)

Recreational activities (including travel) and hobbies: _____

within last 6 months: _____

Animals or pets: _____

Politics: _____

within last 6 months: _____

Exercise/Fitness: _____

within last 6 months: _____

Religious/spiritual practices: Church membership: _____

within last 6 months: _____

"Chores" around the house: _____

within last 6 months: _____

Holiday and special date traditions: _____

within last 6 months: _____

Other interests: _____

_____

SUPPORT SYSTEM

Primary Caregiver Relationship to client: _____

Length of time the individual has been providing care: _____

Caregiver outlook: _____

Physical needs/Health concerns: _____

Support for caregivers: _____

Support from community agencies/organizations: _____

Completed by_____date_____