

FAMILY/CAREGIVER INTAKE

Section A. Caregiver

Client I.D. (CRC Site/Client Number) ____/____		Intake Staff	Intake Date		<input type="checkbox"/> By Phone	<input type="checkbox"/> Add to Mail List
					<input type="checkbox"/> In Person	<input type="checkbox"/> Add to E-Mail List
Caller/Caregiver Last Name			First Name			M.I.
Mailing Address					City	
State	Zip Code	Rural Y N	Housing Status Rent Own Other		Home # ()	
E-Mail Address					Work # ()	Ext.
Referral Source Code CMP FRD MNT NET RDS SSV FAM HLT MPB OBD CRC OTH		Name of Referring Agency			Racial/Ethnic Identity AFR HSP OTH ASI WHT IND	
Name and Title of Referral Source		Language	Sex M F	Marital Status	Date of Birth M ___/D ___/Y ____	
Relationship to Impaired Person WIF DAU BRO MOM FRD SIL OTH HUS SON SIS DAD DIL BIL SISL		Lives w/Impaired Person Y N	Primary Caregiver Y N	Employment FT PT NONE	Low Income Y N	

SECTION B. Dependent Adult

Last Name		First Name			M.I.
Address (If different from Caregiver)			City	State	Zip
Date of Birth M ___/D ___/Y ____		Age	Sex M F	Living Arrangement ALO REL HOS RBC SPO NON REH SNF	
				Nutritional Risk Low Medium High	
Primary Diagnosis Code CVA TBI AD AID ALS HD OND TUM MID MS ODD PD		Primary Diagnosis		Secondary Diagnosis Code CVA TBI AD AID ALS HD OND TUM MID MS ODD PD	
				Secondary Diagnosis	
Diagnosis Confirmed Y N	Diagnosis Date (Optional) M ___/D ___/Y ____		Onset Date Year _____	Medi-Cal Y N	SSI/SSP Y N
Other (Non-BI) Diagnosis		IHSS Y N	Veteran Y N	Health Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> HMO <input type="checkbox"/> Other _____	

SECTION C. Major Problems/Needs Identified (can check more than one)

<input type="checkbox"/> Information about ICRC <input type="checkbox"/> General Information/Orientation to Brain Damage <input type="checkbox"/> Behavior Management Advice <input type="checkbox"/> Diagnostic/Medical Advice <input type="checkbox"/> Direct Care of Brain-Impaired Adult <input type="checkbox"/> Emotional Support <input type="checkbox"/> Financial Advice/Aid	<input type="checkbox"/> Legal Information/Advice <input type="checkbox"/> Long Term Care <input type="checkbox"/> Placement Help (Out of Home) <input type="checkbox"/> Public Policy/Research <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Respite Care (for caregiver) <input type="checkbox"/> Other _____
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