Life Changes
ELDER CARE CONSULTING LLC

Change is Inevitable. Be Proactive!

NEW CLIENT INFORMATION

NAME: ______________________________ **PREFERRED:** __________________________

Address ____

City, St, Zip: ____

Home phone: __________________________ **Cell phone:** ____________________________

Email Address: ____

Presenting Problem(s):____

____

____

Referred by: ____

SSN: __________________________________

DOB: ____

Age: ____

Gender: ______________________________________

Ethnicity: ____________________________________

Language:_____________________________________

Religion/affiliation: ___________________________

Living Environment:____________________________

Years in Boise: _____

Marital Status: ___________Yrs:_____

Spouse Name: _________________________

Spouse Age: ___________________________

Employment Status: ___________________

Employer: ______________________________

Service Branch: _________________________

Discharged Date: _______________________

Rank: _________________________________

Do You have the DD214? _____

PRIMARY CAREGIVER

Name ____

Home phone ___________________________________

Cell phone ____________________________________

Address _______________________________________

Email ____

Relationship __________________________

Work phone____________________________

City, St, Zip __________________________

EMERGENCY CONTACTS

Name ____

Home phone ___________________________________

Cell phone ____________________________________

Address _______________________________________

Email ____

Relationship __________________________

Work phone____________________________

City, St, Zip __________________________

Name ____

Home phone ___________________________________

Cell phone ____________________________________

Address _______________________________________

Email ____

Relationship __________________________

Work phone____________________________

City, St, Zip __________________________

LEGAL REPRESENTATIVES

HEALTH CARE DPOA

Name ______________________________
Home phone ______________________________
Work phone______________________________
Cell phone ______________________________
Fax # ______________________________
Address ______________________________
City, St, Zip ______________________________
Email ______________________________

FINANCIAL DPOA

Name
Home phone ______________________________
Work phone______________________________
Cell phone ______________________________
Fax # ______________________________
Address ______________________________
City, St, Zip ______________________________
Email ______________________________

LEGAL GUARDIAN

Name ______________________________
Relationship ______________________________
Home phone ______________________________
Work phone______________________________
Cell phone ______________________________
Fax # ______________________________
Address ______________________________
City, St, Zip ______________________________
Email ______________________________

BACKGROUND

Born in: ______________________________
Grew up in: ______________________________
Sibling Names: ______________________________
____
Highest level education: ______________________________ Splty: ______________________________
Other degrees: ______________________________ Splty: ______________________________
Occupation: ______________________________
Retired When: ______________________________
Places lived: ______________________________
Hobbies: ______________________________
____
Activities Likes: ______________________________
____
Food Preferences: ______________________________
____
Volunteer Activities: ______________________________
____

CLIENT HEALTH CARE TEAM

Name ______________________ **Specialty** PRIMARY CARE PHYSICIAN

Medical System (if applicable, circle one): St. Luke's, St. Alphonsus, Independent

Work phone ______________________ **Fax #** ______________________

Address ______________________ **City** ______________________

Electronic Health Record – User ID & Password ______________________

Name ______________________ **Specialty** DENTIST

Work phone ______________________ **Fax #** ______________________

Address ______________________ **City** ______________________

Name ______________________ **Specialty** OPTOMETRIST

Work phone ______________________ **Fax #** ______________________

Address ______________________ **City** ______________________

Examples of Medical Professionals

Internal Medicine Splst
Neurologist
Oncologist
Orthopedic Splst
Dermatologist
Chiropractor/Acupuncturist
Nutritionist
Ophthalmologist
Gastroenterology
Other

Name ______________________ **Specialty** ______________________

Phone ______________________ **Fax #** ______________________

Address ______________________ **City** ______________________

Name ______________________ **Specialty** ______________________

Work phone ______________________ **Fax #** ______________________

Address ______________________ **City** ______________________

Name ______________________ **Specialty** ______________________

Work phone ______________________ **Fax #** ______________________

Address ______________________ **City** ______________________

Name ______________________ **Specialty** ______________________

Work phone ______________________ **Fax #** ______________________

Address ______________________ **City** ______________________

PREFERRED PHARMACY

MAIL IN

Name ______________________________ ______________________________

Phone ______________________________ **Fax #**______________________________

Address ______________________________ **City** ______________________________

LOCAL

Name ______________________________ ______________________________

Phone ______________________________ **Fax #**______________________________

Address ______________________________ **City** ______________________________

PREFERRED MEDICAL PRACTICE

Name ______________________________ ______________________________

Phone ______________________________ **Fax #**______________________________

Address ______________________________ **City** ______________________________

PREFERRED HOSPITAL

Name ______________________________ ______________________________

Phone ______________________________ **Fax #**______________________________

Address ______________________________ **City** ______________________________

INSURANCE

Primary Insured Name__________________ **Primary DOB**______________________________

Medicare # ___________________________ **Medicaid #**______________________________

Other Ins Name ______________________ **Other ID #**______________________________

If Medicaid, Social Worker ____

END OF LIFE PLANNING

Funeral Home _________________________ **Cemetery Plot #**__________________________

Funeral Arrangements ____

LIFE CHANGES ELDER CARE CONSULTING, LLC * www.lifechangeseldercare.com * 208-321-5567

PRIMARY CONTACTS

Name ________________________________ Relationship __________________________
Home phone __________________________ Cell Phone ____________________________
Work phone __________________________ Fax #_________________________________
Address ______________________________ City, State, Zip ________________________
Email ________________________________ Email ________________________________

Name ________________________________ Relationship __________________________
Home phone __________________________ Cell Phone ____________________________
Work phone __________________________ Fax #_________________________________
Address ______________________________ City, State, Zip ________________________
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Name ________________________________ Relationship __________________________
Home phone __________________________ Cell Phone ____________________________
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Name ________________________________ Relationship __________________________
Home phone __________________________ Cell Phone ____________________________
Work phone __________________________ Fax #_________________________________
Address ______________________________ City, State, Zip ________________________
Email ________________________________ Email ________________________________

OTHER SERVICE AGENCIES INVOLVED

Agency ________________________________ **Specialty** ________________________________

Name ________________________________

Phone________________________________ **Fax #**________________________________

Address ________________________________ **City** ________________________________

Agency ________________________________ **Specialty** ________________________________

Name ________________________________

Phone________________________________ **Fax #**________________________________

Address ________________________________ **City** ________________________________

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