

Silver Wings Arts Program Client Intake

Client Name: _____

Address: _____

Telephone: _____ (Cell)

_____ (Home)

Client DOB: _____ M _____ F _____

How did you hear about Silver Wings Arts Program? _____

Which days of the week are you interested in attending? Circle. M T W TH F

Past/present occupation: _____

List hobbies and interests, past and present:

_____	_____
_____	_____
_____	_____
_____	_____

List activities you would like to explore:

Preferred Diet Type: _____ i.e. (low salt, no sugar, vegan, etc.)

Favorite Snacks: _____

Favorite Beverages: _____

Dietary Restrictions: _____

Food Allergies: _____

If requiring basic caregiving oversight, please complete the following sections A - G:

A. Mobility:

Assistive Devices used:

Walker _____
Cane _____
Wheelchair _____
Other _____

B. Has there been a fall incident in the past 12 months? _____, if so, was surgery required? _____ Date _____

C. Has there been any hospitalization in the past 12 months? _____ Date _____

Adaptive Devices used:

Hearing Aid _____
Dentures _____
Glasses _____
Other _____

D. Does the Client live with a neurodegenerative, dementia-related illness such as Alzheimer's, Parkinson's, Huntington's, etc? _____ If yes, what is the specific diagnosis, if known? _____ Date of diagnosis? _____ Current stage of illness? _____

E. Does the client have a MOST form? _____ A DNR? _____

F. Client's Primary Physician Name: _____
Address: _____
Phone: _____

G. Date of last Doctor's visit: _____
Preferred Hospital in case of emergency: _____

Client Signature

Date

or

Client Representative Signature

Date

Relationship to Client