DOXA Empowerment Foundation Agency

Client Assessment Form

This form binds the client and the agency to ensure productive care giving
Please write down, circle or check all that apply

1 Full Name of client

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2 Full address

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3 Email address/contact phone number

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4 Type of care required

Companionship Personal Care or both

Other—----------

5. Live in or Live out

If Live -out , State # of days/ hours of day (week days and/or week ends)

—----------

If live- in State duration of days/months/ years required

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General health care overseeing , medicals , prescription usage and appointment reminders

Yes No

Companionship

Personal supervision providing constant companionship and general supervision

Yes No

Emotional Support: Stable companionship in all health and emotional issues

Yes No

Dimentia/ Alzheimers diseases

Relaying information from doctors to family members

Yes No

Personal Care

Mobility assistance

Help with getting in and out of wheelchair, bed, car, shower etc

Yes No

Getting help with cooking, bathing, house cleaning and others : state

others—----------

Assisting with errands such as grocery, shopping etc for the client only

Yes No

Circle all that apply

Assisting with

Feeding, Hair, nail care, oral hygiene, bathing, grooming and dressing, , light house keeping, dish washing, laundry, meal preparation, incontinent care and/or toileting

Health Monitoring

Following a care plan, noticing any changes in the client health, recording and reporting differences