

(Insert Church Name and/or Logo)

Initial Contact Sheet

Date _____

Name _____ Date of Birth _____

Home Address _____

Phone (Home) _____ (Business) _____ (Personal) _____

Marital Status: _Single _Married _Divorced _Widow/Widower Sex: M/F Race _____

CHIEF COMPLAINT:

BP _____ **P** _____ **R** _____ **Wgt.** _____

CURRENT MEDICATION(S)/DOSAGES:

IDENTIFIED NEEDS: (Meals on Wheels, transportation to rehabilitation services, physicians' visits, etc.)

BRIEF PROFILE OF CURRENT LIVING CIRCUMSTANCES/SAFETY CONCERNS:

FUNCTIONAL LIMITATIONS: (Cane, walker, difficulty performing activities of daily living, such as bathing, dressing, toileting, etc...)

FINANCIAL NEEDS:

COMUNITY SERVICE CURRENTLY PROVIDED:

CAREGIVER STATUS:

SPIRITUAL NEEDS (such as):
Prayer requests for:

_____ Home Communion

_____ Stephen's Minister/BeFriender

_____ Care Caller

_____ Home/Church Bible Study

CURRENT PHYSICIAN(S)

1.) Name _____ Specialty _____

Address _____ Phone _____

2.) Name _____ Specialty _____

Address _____ Phone _____

PERSON(S) TO NOTIFY OF HEALTH EVENTS/NEEDS AND/OR EMERGENCIES

1. Name _____ Relationship _____

Address _____

Phone (Home) _____ (Business) _____ (Cell) _____

2. Name _____ Relationship _____

Address _____

Phone (Home) _____ (Business) _____ (Cell) _____

PERSON HAVING DURABLE POWER OF ATTORNEY FOR HEALTHCARE (If applicable)

Name _____ Relationship _____

Address _____

Phone (Home) _____ (Business) _____ (Cell) _____

CPR/DNR STATUS:

Date _____

I, _____ give permission for
(name)
_____, a representative of
_____ to contact or share health information
(Church Name)
with my physician(s) and/or contacts listed on this form. I further understand that I
am responsible for follow-up with my physician or health care provider for all personal
medical conditions and problems.

(Signature) (Date)

CHAMPS
Center for Healthy Aging, Ministries, Programs & Services
13271 Millard Avenue
Omaha, Nebraska 68137
Tel: (402) 895-2224
Website: www.champsonline.info
Email: champs@crossandheart.org

CHAMPS is funded by a grant from the Alegant Health Community Benefit Trust

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Health History Form

System Review: Check “yes” if problem is present. In comments section give brief description of problem to correspond with the numbered category.

	Yes	No		Yes	No
General			16. Frequency		
1. Appetite (nutrition problems)			17. Nocturia		
2. Fatigue			18. Sexuality		
3. Weight Change			Cerebral		
4. Sleep			19. Memory Loss		
5. Depression			20. Confusion		
6. Hearing Loss			21. Headaches		
7. Vision Changes			22. Transient weakness or visual symptoms (TIAs)		
8. Alcoholism			Cardiovascular		
Locomotion			23. Heart Attack(s)		
9. Morning stiffness/arthritis			24. Congestive Heart Failure		
10. Pain			25. Pacemaker/Defibrillator		
11. Range of motion			Gastrointestinal		
12. Balance/gait			26. Stomach or Bowel Problems		
13. History of falls or balance problems			Endocrine		
14. Foot problems including need for toenail care			27. Diabetes Mellitus (Insulin or non-insulin dependent)		
Genitourinary			28. Thyroid		
15. Incontinence			29. Cancer		

(Adapted from Ham RJ: Geriatrics. I. Monograph ed.89. Home Study Self-Assessment Program, Kansas City, MO.. Oct. 1986, American Academy of Family Physicians)

State brief history of health concerns for each “Yes” item checked above.

(Ex. 19. Diagnosed with Alzheimer’s 6 months ago. Takes own medication and continues with self care with intermittent assistance from family.)

-Over-

continued

Name of Interviewer _____ **Date** _____