CREATIVE & HOLISTIC AGING SERVICES
10 WATCH COURT
REISTERSTOWN, MD 21136
443.858.1161

CONSULTATION DATE: _____

PLEASE COMPLETE THE FOLLOWING INFORMATION:

PATIENT INFORMATION:

NAME _____

ADDRESS _____

CITY, STATE ZIPCODE _____

TELEPHONE/CELL# _____

REFERRED BY: _____

REFERRAL DISCOUNT/WAIVER OF FEE: _____

MEDICAL HISTORY:

DX1:_____ DATE _____

DESCRIPTION _____

_____

DX2:_____DATE_____

DESCRIPTION _____

_____

DX3:_____DATE_____

DESCRIPTION _____

_____

DX4: _____DATE_____

DESCRIPTION _____
MEDICATION (INDEPENDENT / NEEDS ASSISTANCE)

NAME _____ DOSAGE _____ USAGE_____
SIDE AFFECTS/COMMENTS: _____

_____

_____

NAME _____DOSAGE _____USAGE_____
SIDE AFFECTS/COMMENTS: _____

_____

_____

NAME _____DOSAGE _____USAGE_____
SIDE AFFECTS/COMMENTS: _____

_____

_____

ADDITIONAL MEDICAL INFORMATION:

COMMENTS: _____

_____

_____

_____

_____

PERSONALITY/CHARATERISTICS: _____

_____

LIKES/DISLIKES: _____

_____

HOBBIES: _____

_____

SERVICES REQUIRED: COMPANION CARE / SKILLED NURSING (RN, LPN, CNA, GNA, CMA)/ NURSING ASST
RATE OF PAY $_____/HOURLY RATE

Special Services Required: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

HOUSEKEEPING SERVICES: YES OR NO (IF YES, PLEASE DESCRIBE TYPE OF SERVICE)

_____

_____

TRANSPORTATION SERVICES: YES OR NO (IF YES, PLEASE DESCRIBE TYPE OF SERVICE AND HOW OFTEN)

_____

_____

HOW OFTEN WILL YOU REQUIRE SOMEONE? _____

_____

TEMPORARY SERVICES: START DATE _____ END DATE_____

INDEFINITE SERVICES: START DATE _____ NO END DATE

HOSPITAL CARE: START DATE _____ END DATE _____

POST-SURGERY CARE: START DATE _____END DATE_____
TYPE OF SURGERY: _____
CONTACT NAMES & ADDRESS

CONTACT 1: NAME _____

ADDRESS _____

CITY, STATE, ZIPCODE _____

TELEPHONE/CELL# _____

RELATIONSHIP TO PATIENT _____

CONTACT 2: NAME _____

ADDRESS _____

CITY, STATE, ZIPCODE _____

TELEPHONE/CELL# _____

RELATIONSHIP TO PATIENT _____

CONTACT 3: NAME _____

ADDRESS _____

CITY, STATE, ZIPCODE _____

TELEPHONE/ CELL# _____

RELATIONSHIP TO PATIENT _____

CONTACT 4: NAME _____

ADDRESS _____

CITY, STATE, ZIPCODE _____

TELEPHONE/CELL# _____

RELATIONSHIP TO PATIENT ____