MINT GROUP PRIVATE CARE

COMPASSIONATE CARE • PERSONAL SUPPORT • PEACE OF MIND

Care Assessment

Getting to Know You So We Can Care for You

Client Name: _____

Assessment Date: _____

Compassionate Care. Right at Home. ♥

CLIENT INFORMATION

Full Name:

Preferred Name / Nickname: **Date of Birth:**

Home Address:

City: **State:** **Zip:**

Phone Number: **Email Address:**

Primary Language:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Veteran: ☐ Yes ☐ No

How did you hear about Mint Group Private Care?:

EMERGENCY CONTACT INFORMATION

Primary Emergency Contact:

Relationship: **Phone Number:**

Alternate Emergency Contact:

Relationship: **Phone Number:**

PHYSICIAN INFORMATION

Primary Care Physician:

Phone Number: **Preferred Pharmacy (optional):**

Address:

In the event of an emergency, I give permission for Mint Group Private Care to contact the above individuals and seek emergency medical care if needed.

Client/Guardian Signature: _____ Date: _____

MEDICAL INFORMATION

Primary Diagnosis / Condition:

Other Medical Conditions:

Allergies (please list):

Current Medications (please list)

Medication	Dosage	Frequency	Prescribing Doctor

Do you have any of the following?

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease
- ☐ COPD / Respiratory Issues
- ☐ Arthritis
- ☐ Dementia / Alzheimer's
- ☐ Depression / Anxiety
- ☐ Vision Impairment
- ☐ Hearing Impairment
- ☐ Other: _____

FUNCTIONAL ASSESSMENT

Please check the level of assistance currently needed for each activity.

Daily Activity	Independent	Needs Supervision	Needs Some Help	Dependent (Full Help)
🛁 Bathing	☐	☐	☐	☐
👕 Dressing	☐	☐	☐	☐
🪥 Grooming	☐	☐	☐	☐
🚽 Toileting	☐	☐	☐	☐
💧 Continence	☐	☐	☐	☐
🔄 Transfers (bed, chair)	☐	☐	☐	☐
🚶 Walking / Mobility	☐	☐	☐	☐
🍽️ Eating	☐	☐	☐	☐
💊 Medication Reminders	☐	☐	☐	☐
🧹 Housekeeping	☐	☐	☐	☐
🧺 Laundry	☐	☐	☐	☐
🚗 Transportation	☐	☐	☐	☐
🛒 Shopping	☐	☐	☐	☐
👥 Companionship	☐	☐	☐	☐

Do you use any of the following?

☐ Cane ☐ Walker ☐ Wheelchair ☐ Hospital Bed

☐ Other: _____

Are there any recent falls? ☐ Yes ☐ No

If yes, please explain:

COGNITIVE ASSESSMENT

Memory (describe any concerns or changes):

Orientation (to person, place, time):

Diagnosed Dementia or Memory Condition ☐ Yes ☐ No

Communication Ability:

Behavioral Concerns:

Safety Concerns:

Wandering Risk ☐ Yes ☐ No

DAILY ROUTINE & PREFERENCES

What time do you typically wake up?:

What time do you go to bed?:

Do you take naps? ☐ Yes ☐ No

If yes, when?:

Meals (typical times & preferences):

Medications (typical times):

What are your favorite activities or hobbies?:

Do you have any special dietary needs or preferences?:

Religious or Cultural Preferences:

What is most important to you in your care?:

HOME ENVIRONMENT & SAFETY

Do you live: ☐ Alone ☐ With Family ☐ With Spouse ☐ Other: _____

Home Type: ☐ House ☐ Apartment ☐ Condo ☐ Other: _____

Are there stairs in the home? ☐ Yes ☐ No

If yes, where?:

Are there pets in the home? ☐ Yes ☐ No

If yes, what kind?:

Home Safety Checklist

☐ Throw Rugs ☐ Smoke Detectors ☐ Grab Bars

☐ Adequate Lighting ☐ Clear Emergency Exits ☐ Firearms in Home

Are there any safety concerns or areas we should be aware of?:

Your safety and comfort are our priority. Please let us know about anything in your home that we should be aware of.

CAREGIVER PREFERENCES

Do you have a preference for male or female caregiver? ☐ No Preference ☐ Female ☐ Male

Is there anything you would like your caregiver to know about you?:

Is there anything you would like your caregiver not to do?:

Are there specific cultural or religious considerations we should be aware of?:

FAMILY GOALS & PRIORITIES

What are your biggest concerns right now?:

What would you like help with?:

What does a successful care plan look like to you?:

RECOMMENDED CARE PLAN

For office use — completed by your Care Coordinator following the assessment.

Recommended Services:

Suggested Schedule:

Hours Per Week: **Start Date:**

Special Instructions / Notes:

AUTHORIZATION & CONSENT

- ☐ I understand that this assessment is used to create a personalized care plan to meet my needs.
- ☐ I consent to the sharing of this information with Mint Group Private Care staff involved in my care.
- ☐ I understand that my care plan will be reviewed and updated as needed.
- ☐ I understand this signature acknowledges participation in the assessment only and does not obligate me to purchase services.

Client / Guardian Signature _____ **Date** _____

Print Name: _____

Assessment Completed By

Care Coordinator Signature Brittney Williams **Date** _____

Title: Founder & Care Coordinator, CNA

Thank You

We look forward to providing you with compassionate care, right at home.

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