CARRIAGE HILL
ASSISTED LIVING

Initial Health Questionnaire

Name: _____ Date of Birth: _____

Current living situation? _____

_____

Why is a residential care facility being considered? _____

_____

Anticipated date of admission, if known: _____

Type of assistance needed:

Assistance with Activities of Daily Living? Yes / No

Assistance with medication administration? Yes / No

Assistance with mobility? Yes / No

Other? Please explain. _____

_____

Do you use a mobility device?

____ Cane ____ Walker _____ Wheelchair _____ Electric Wheelchair/Scooter _____ Other

Do you current have any medical conditions? _____

_____

_____

_____

Do you currently take any medications? Please list. _____

_____

_____

_____

Are you a smoker? Yes / No

Do you have any pet allergies? Yes / No