CLIENT/FAMILY INTAKE FORM

Elim Faith Community Nursing
A Ministry of Elim Care
SERVING IN THE SPIRIT OF CHRIST'S LOVE

Office: _____ *Cell:* _____
Email: _____ *Website:* _____

Date			**Time**	
Contact Information	**Client/Family Name**			
	DOB	**Age/Age Range**	**Gender** M ☐ F ☐	**Marital Status** Single
	Address	**City**	**State**	**Zip**
	Phone (H)	**Phone (C)**	**Email**	

Name	Family/ Significant Others	Relationship	Address	Phone

*indicates emergency contact

Client Congregational Status ☐ **Member** ☐ **Non-member**

Best time/ day for visit	**Place for first visit**	
Priority: ☐ **High** ☐ **When available**		
Person assigned for first visit		**Date**

Purpose of Contact

☐ Spiritual	☐ Psychosocial	☐ Cancer	☐ Endocrine
☐ Cardiovascular	☐ Chronic Disease	☐ GU/Reproductive	☐ Neurological
☐ Infectious Disease	☐ Mental Health	☐ Musculoskeletal	☐ Pulmonary
☐ Sensory	☐ Information/Resources	☐ Safety/Environment	☐ Other (specify)
☐ Financial			

FOR OFFICE USE ONLY	
Parish Nurse Signature	
Congregation	