Intake Form

Please complete the Intake Form and return it in the enclosed self-addressed stamped envelope.

Name: _____ DOB: _____

Address: _____ Phone: _____

_____ Work: _____

_____ Cell: _____

Email: _____ Marital Status: M S D W

Employer: _____ Position: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Referred to our Chapter by: _____

Date of diagnosis: _____ Social Security #: _____

Interested in: clinic: _____ respite: _____ transportations: _____
equipment loan: _____ support group: _____ home visit: _____
literature: _____ newsletter: _____ other: _____

Add to mailing list: Yes_____ No_____

Given a RI Chapter Package: _____

Primary Insurance: _____ Policy #: _____

Insured Name: _____

Secondary Insurance: _____ Policy #: _____

Insured Name: _____

Lives with: Alone Spouse Spouse and Family Family Nursing Facility

Are you a veteran? Yes_____ No_____

Will you consider joining the ALS Registry? Yes_____ No__

Contacts:

Name Relationship Phone

Address Email

Name Relationship Phone

Address Email

Name Relationship Phone

Address Email

Do you have any needs that our Chapter may be able to help you with at this time? (please circle below)

Educational Materials	Support Groups	Other
Home Equipment Loans	Communication Equipment	_____
Respite Care	Durable Medical Equipment Loans	_____

Are you presently receiving any services? Yes_____ No_____

Name of Agency: _____ Contact Person: _____

Name of Agency: _____ Contact Person: _____

Please list all medications you are currently taking including over the counter medications and vitamins:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

If you have a medication list available, please include it when returning this packet.

Past Medical/ Surgical History: (hospitalizations, illness)

_____ _____
(Illness, surgery, etc.) (Date)

_____ _____
(Illness, surgery, etc.) (Date)

_____ _____
(Illness, surgery, etc.) (Date)

Have you had any Pulmonary Testing (PFT or Spirometry) within the past year? Yes_____ No_____

If yes, approximate date and location _____

What is your current weight? _____

When was your last flu shot? _____

Are you up to date with your pneumonia vaccines? Yes_____ No_____

When was your last injection? _____

In the space provided please provide information concerning any areas where you are having difficulty or require assistance.

Breathing: _____

Eating: _____

Speaking: _____

Writing: _____

Self-Care (bathing, brushing teeth, etc.) _____

Walking: _____

Homemaking (cooking, cleaning, etc.):
_____

Are there any barriers in your home that limit mobility (stairs, narrow doorways, etc.)?

_____

Please return this form in the envelope provided or to the following:

ALS Association
Rhode Island Chapter
2374 Post Road Suite 103
Warwick, RI 02886