Little Angels Home Care LLC

240 Myrtle Street

Shelton CT, 06-484

203-278-1436

**New Client Questionaire**

Referred by:……………………………….. Date:……………………………………………

Name of caller:…………………………………………………………………………………

Phone number:………………………………………………………………………………...

Address:………………………………………………………………………………………...

City:…………………………………State:…………………..Zip code:…………………….

**Services Requested**

Elderly Care: Live-in, Hourly, Nights, Weekends

Start date:………………………………………………………………………………………

Days requested: **M Tu W Th F Sa Su**

**Services requested (circle all that apply)**

Cleaning, Shower, Meals, Driving, Dress, Grocery, Remind of Meds, Laundry, Exercise, Cook, Mapping the floor

Salary:……………………………………English speaking: **yes no**

Car needed: **yes no** Age preference:…………………………………………..

**Name of patient:**……………………………………………………………………….

Address:………………………………………………………………………………………...

City:…………………………………State:…………………..Zip code:…………………….

**Medical Conditions (circle all that apply):**

Alzheimer, Cancer, Incontinence, Depression, Pulmonary Disease, Diabetes, Heart Diseade, Parkinson