Harp Cares

Compassionate care you can trust

(204) 915-8574 | bookings@harpcares.ca | www.harpcares.ca

Services available in English and Punjabi

Client Health & Intake Form

Schedule A — Attachment to Client Service Agreement

Instructions: Please complete all sections as accurately and fully as possible. This form is confidential and will only be used by Harp Cares to provide safe, appropriate companion support. It must be completed and signed before services commence. Update Harp Cares promptly if any information changes.

A. CLIENT INFORMATION

First Name: _____ **Last Name:** _____

Date of Birth (DD/MM/YYYY): _____ **Preferred Name / Nickname:** _____

Home Address: _____

City: _____ **Postal Code:** _____

Phone (primary): _____ **Phone (alternate):** _____

Email Address: _____

Primary Language: _____ **Secondary Language (if any):** _____

B. AUTHORIZED REPRESENTATIVE / FAMILY CONTACT

Person authorized to make decisions on behalf of the client, or primary family contact:

Full Name: _____ **Relationship to Client:** _____

Phone (primary): _____ **Phone (alternate):** _____

Email Address: _____

Type of Authority (e.g. Power of Attorney, Healthcare Proxy, Family Member): _____

C. HEALTH OVERVIEW

This information helps Harp Cares understand the client's needs and respond appropriately in any situation. **Harp Cares does not provide medical services — this information is for safety and awareness only.**

Does the client have any of the following? (Check all that apply)

- ☐ Diabetes
- ☐ Heart condition / cardiovascular disease
- ☐ Dementia / Alzheimer's disease
- ☐ Parkinson's disease

- ▫ Stroke history
- ▫ Epilepsy / seizure disorder
- ▫ Mental health condition
- ▫ Hearing impairment
- ▫ Incontinence
- ▫ Other (please specify below)
- ▫ COPD / respiratory condition
- ▫ Cancer (current or recent treatment)
- ▫ Vision impairment
- ▫ Mobility impairment

Please describe any checked above, or any other relevant health information:

D. MEDICATIONS

Harp Cares does not administer medications but may provide reminders. Please list current medications so the provider is aware in case of emergency.

MEDICATION NAME	DOSE / FREQUENCY	PURPOSE (brief)

Does the client manage their own medications independently?

- ▫ Yes, independently
- ▫ With some reminders
- ▫ Requires full support from family/nurse

E. ALLERGIES & ADVERSE REACTIONS

Does the client have any known allergies or adverse reactions?

- ▫ No known allergies
- ▫ Yes — please list below

Allergy / Reaction details (include triggers and typical reaction):

Does the client carry an EpiPen or emergency medication?

- ▫ No
- ▫ Yes — location in home:

F. MOBILITY & PHYSICAL NEEDS

How does the client get around?

Fully independent | Uses a cane | Uses a walker | Uses a wheelchair

Requires arm support / steadying | Limited stair mobility | Fall risk (history of falls) | Other — see below

Important: *Harp Cares does not perform physical transfers, lifts, or personal hygiene assistance. If the client requires this level of support, please arrange a regulated home care provider.* **Additional mobility notes:**

G. COGNITIVE & COMMUNICATION NEEDS

Cognitive status:

Fully oriented | Mild memory difficulties | Moderate cognitive impairment | Dementia / Alzheimer's

Communication:

Speaks and understands English well | Limited English — primary language:

Primary language (if not English):

Uses speech normally | Speech difficulty | Non-verbal / uses gestures | Uses communication device

Any additional notes on communication or cognitive needs:

H. HOME ENVIRONMENT

Type of residence:

- ▫ Private home
- ▫ Apartment / condo
- ▫ Assisted living facility
- ▫ Other:

Are there any of the following in the home?

- ▫ Pets (please describe below)
- ▫ Stairs or steps
- ▫ Elevator access

Pet details (type, breed, temperament — especially if relevant to provider safety):

Building entry code or key access instructions (if applicable):

Are there any known hazards or safety concerns in the home?

- ▫ No
- ▫ Yes — please describe below

Safety / hazard details:

I. CLIENT PREFERENCES & DAILY ROUTINES

This section helps Harp Cares provide care that feels personal, respectful, and comfortable for the client.

Preferred daily schedule / usual routine (meals, rest, activities):

Hobbies, interests, and favourite topics of conversation:

Things that bring the client comfort or joy:

Things that cause the client distress or that should be avoided:

Preferred form of address (e.g. first name, Mr./Mrs.):

Religious / cultural considerations (if applicable):

J. GOALS FOR SERVICE

What are the main goals for engaging Harp Cares? (Check all that apply)

- ☐ Reduce social isolation / companionship
- ☐ Wellness check-ins / monitoring
- ☐ Post-hospital or post-surgery recovery support
- ☐ Errand support (pharmacy, groceries)
- ☐ Support with appointments
- ☐ Light household help
- ☐ Respite support for family caregivers
- ☐ Other — see below

Any additional goals or context the provider should know:

K. DECLARATION & SIGNATURE

I confirm that the information provided in this form is accurate and complete to the best of my knowledge. I understand that Harp Cares will rely on this information to deliver safe and appropriate companion services. I agree to notify Harp Cares promptly if any information in this form changes.

CLIENT OR AUTHORIZED REPRESENTATIVE

Signature _____

Printed Name: _____ **Date:** _____

Relationship to Client (if not client): _____