Canyonlands Care Center
390 West Williams Way
Moab, UT 84532
435/719-4400 Tel.
435/719-4401 Fax

Application and Intake Questionnaire

Applicant's Name: _____ Date: _____

Address: _____

Male Female Social Security Number: _____

Date of Birth: _____/_____/_____ Age: _____ Marital Status: M S W D

Physician: _____ Dentist: _____
Medicare #: _____ Medicaid #: _____

Current diagnosis or medical problems:
_____
_____
_____

Medications and Treatments
Medications: Dose: Time/How Often:
_____
_____
_____
_____
_____

Allergies: _____

Currently Ambulates: ___independently ___with cane/walker ____wheelchair bound
Current Activity Level: _____
Eating/Special Diet: _____
Feeds Him/Herself: _____
Food Allergies: _____
Food Dislikes: _____
Dressing
Dress Him/Herself: Yes No Needs Help With: _____

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Sleep

Difficulty Sleeping: Yes No
Usual Sleeping Pattern: _____
Naps: Yes No When: _____

Orientation: Confused? Yes No Forgetful? Yes No
Behavior: Cooperative? Yes No

Wets the bed? Yes No
Toileting: Needs assistance? Yes No Requires adult diapers? Yes No

Able to ask for assistance? Yes No

Current living situation: _____
Currently ready for placement? Yes No If not, when? _____

Any special devices needed? _____
Special Instructions: _____

Recreation/Interests: _____
Dislikes: _____
Other Information/Previous Occupation: _____
Church Affiliation: _____

Anything else you feel we should know:
_____
_____
_____

Contact Person: _____ Phone: _____

Address: _____

Relationship to Applicant: _____

_____ _____
Signature Date