

Go-Fors, Inc. TOO

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CLIENT ASSESSMENT INFORMATION

Date: _____ Completed by: _____

Name: _____ F / M Telephone: _____

Name of Facility: _____ Facility Telephone: _____

Street: _____ City, State, Zip: _____

Directions to location: _____

PERSONAL INFORMATION

Marital Status: Married: ____ Single: ____ Widowed: ____ Birthday: _____

Living Status: House: ____ Facility: ____ Group Home: ____ Nursing Facility: _____

Health: Ambulatory: ____ Cane: ____ Walker: ____ Wheelchair: ____

Standard size wheelchair: Y / N If No, width of chair in inches _____

Health Concerns: _____

Medications: _____

Allergies: _____

SERVICES

Primary individual who will

Schedule appointments: _____ Telephone: _____

Type of Services requested: Medical: ____ Grocery: ____ Salon: ____ Outings: ____

Day, Date Time, Location of upcoming appointments: _____

Emergency Contact Name: _____ Relationship: _____

Telephone: Home: _____ Work: _____ Cell: _____

Street Address: _____ City, State, Zip: _____