



CLIENT & FAMILY INTAKE FORM

Please complete before scheduling or before the home visit.

Purpose: This brief intake helps In-Place Able prepare for a private-pay home environment consultation focused on physical adaptations. It is not a clinical evaluation, treatment session, or emergency service.

1 Contact and client information

Client name	Preferred name
Date of birth	Pronouns (optional)
Client phone	Client email
Home address	City / State / ZIP

Who is completing this form?

☐ Client	☐ Adult child	☐ Other: _____
☐ Spouse / partner	☐ Caregiver	
Name of person completing form	Relationship to client	
Best phone number	Email address	

Best way to contact you: ☐ Phone ☐ Email ☐ Text Best days / times: _____

2 What is getting harder at home?

Check all that apply. Use the space below for anything not listed.

☐ Getting into or out of the home	☐ Bedroom access or setup	☐ Using a walker / wheelchair at home
☐ Stairs or moving between levels	☐ Kitchen access or meal tasks	☐ Reaching, bending, or carrying
☐ Bathroom access or safety	☐ Laundry or household tasks	☐ Concern about future accessibility
☐ Bathing / showering setup	☐ Lighting or visibility	☐ Caregiver safety or effort
☐ Toilet access or transfers	☐ Doors, thresholds, or flooring	☐ Other: _____

In your own words, what has become difficult or concerning?



3 Home overview

Home type: ☐ Single-family ☐ Townhome ☐ Apartment / condo ☐ Assisted living ☐ Other: _____

How many total levels? _____	Which levels does the client use? _____
Bedrooms / bathrooms _____	Year built (if known) _____
Who lives in the home? _____	Pets in the home? _____
Entrance used most often _____	Steps at that entrance? ☐ No ☐ Yes: _____

Current access features: ☐ Ramp ☐ Handrails ☐ Grab bars ☐ Stair lift ☐ Elevator ☐ Walk-in / roll-in shower ☐ None

Anything the clinician should know about parking, entry, gates, stairs, or pets before the visit?

4 Falls in the past year

Has the client fallen in the past 12 months? ☐ No ☐ Yes ☐ Unsure If yes, how many times? _____

Where did the fall(s) occur? _____	Was medical attention needed? ☐ No ☐ Yes
Any near-falls or fear of falling? _____	What was happening just before the fall? _____

5 Priorities for the consultation

Goal 1 _____	Why this matters now _____
Goal 2 _____	Why this matters now _____
Goal 3 _____	Why this matters now _____

Who should be part of recommendations or decisions? ☐ Client ☐ Family ☐ Caregiver ☐ Contractor ☐ Other: _____

6 How did you hear about In-Place Able?

☐ Friend / family	☐ Senior community	☐ Online search	☐ Event / presentation
☐ Healthcare provider	☐ Contractor / designer	☐ Social media	☐ Other: _____

7 Acknowledgment and follow-up

I confirm that the information above is accurate to the best of my knowledge. I understand this intake is for scheduling and visit preparation; it is not treatment or emergency care. I authorize In-Place Able to contact me about this request.

Signature _____	Printed name _____
Date _____	Relationship to client (if applicable) _____

If there is an immediate safety concern or medical emergency, call 911 or the appropriate local emergency service.