



SUPPLEMENTAL MEDICAL INFORMATION
LONG-TERM CARE PLANNING INFORMATION FORM
(Please complete one of these forms for both client and spouse)

Client: _____ **SSN:** _____ **DOB:** _____

MEDICAL HISTORY (Check box of all that apply and briefly describe)

- ☐ Stroke _____ Number _____ Onset Date _____
- ☐ Heart Attack _____ Heart Failure _____
- ☐ Severe Heart Condition _____ Onset Date _____
- ☐ Chronic Respiratory Disorder (e.g. Bronchitis, Emphysema)
- ☐ Insulin Dependent Diabetes
- ☐ Rheumatoid Arthritis _____ Onset Date _____
- ☐ Cancer _____ Onset Date _____

In the past 10 years, I have been diagnosed as having, received medication for or been treated by a medical practitioner for:

- ☐ ALS (Lou Gehrig's Disease)
- ☐ Alzheimer's Disease: Diagnosis/Onset Date(s)- _____
- ☐ Central Nervous System Disease
- ☐ Cerebral Palsy
- ☐ Crohn's Disease
- ☐ Cystic Fibrosis
- ☐ Dementia: Diagnosis/Onset Date(s)- _____
- ☐ Hepatitis B, or C, Chronic
- ☐ Huntington's Disease
- ☐ Kidney Dialysis
- ☐ Kidney Disease, Chronic
- ☐ Liver Disease, Chronic
- ☐ Motor Neuron Disease
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Respiratory or Lung Disease, Chronic (other than controlled asthma)
- ☐ Ulcerative Colitis

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Any additional pertinent medical information that would be helpful. Please explain: _____

MEDICATIONS _____ Yes _____ No. Are you currently taking any medications? If yes, please provide details in the space below.

Drug Name	Dosage	Frequency of taking	Reason For Taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SELF-CARE (I currently need assistance or supervision of another person in performing the following activities):

	No Assistance	Some Assistance	Total Assistance
Bathing	_____	_____	_____
Dressing	_____	_____	_____
Moving in/out of bed or chair	_____	_____	_____
Toileting	_____	_____	_____
Bowel/Bladder Control	_____	_____	_____
Eating	_____	_____	_____
Taking Medications	_____	_____	_____

I currently use (check all that apply):

- ☐ Walker
- ☐ Respirator
- ☐ Motorized Cart
- ☐ Wheelchair
- ☐ Chairlift
- ☐ Oxygen
- ☐ Quad Cane (4 pronged cane)
- ☐ Dialysis

ADDITIONAL INFORMATION (Briefly describe any other pertinent medical history or conditions that are not addressed above)
