Senior Care Form

Senior's name: _____

Date of birth: _____

Address: _____

Phone number: _____

Special needs? _____

Doctor: _____ Phone number: _____

Address: _____

Dentist: _____ Phone number: _____

Address: _____

Eye doctor: _____ Phone number: _____

Address: _____

Physical/Occupational therapist: _____

Phone number: _____

Address: _____

Mental health/cognitive ability:

☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Depends on the day

Medications

Medication	Dose	Time

Allergies: _____

Food Preferences

Breakfast	Lunch	Dinner	Snacks

TV Show Preferences

Show	Time

Routine/Activities

Daytime Routine:

_____

_____

Nightime Routine:

_____

_____

Friends and Phone Numbers:

_____ _____

_____ _____

_____ _____

Needs

Cane? ☐ yes ☐ no Wheel chair? ☐ yes ☐ no

Someone with them all of the time? ☐ yes ☐ no