



In-Home Supportive Services (IHSS) Medical and Household Information Sheet

TO BE COMPLETED BY THE CLIENT

SECTION 1: CASE INFORMATION	
Date:	Case Number:
Client Name:	Phone Number:
Client Address:	
Emergency Contact:	Phone Number:

SECTION 2: PERSONS LIVING IN THE HOME			
	Name	Relationship	DOB
1			
2			
3			
4			
5			

SECTION 3: PHYSICIAN/SPECIALIST INFORMATION				
Physician/Specialist Name	Specialty Type	Phone Number	Appointment Frequency	City of Physician/Specialist Office
<i>Example: Dr. Wellness</i>	<i>Primary</i>	<i>(650) 123-4567</i>	<i>2 x per year</i>	<i>San Mateo</i>

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SECTION 4: DISABLING CONDITION(S)/DIAGNOSIS	
<i>Example: Rheumatoid Arthritis</i>	

SECTION 5: CURRENT MEDICATIONS				
Date Filled	Name of Medication	Dosage	Frequency	Reason for Medication
<i>11/01/15</i>	<i>Example: Tylenol</i>	<i>100 mg</i>	<i>2 x per day</i>	<i>Pain</i>

SECTION 6: FOR COUNTY USE ONLY