Town of Stow Council on Aging - Client Database Form

Todays Date: _____ STAFF USE ONLY: _____ New _____ Updated Date ____/____/____ Initials ___

First Name: _____ MI: _____ Last Name: _____ Nickname: _____

Date of Birth: _____/_____/_____ Tel: #: Home: ( )_____ Cell: ( ) _____

Email: _____ Street Address: _____ PO Box: _____

City/Town: _____ Zip code:_____ Gender: ☐ Male ☐ Female

Ethnicity: ☐ African American ☐ Am Indian/Alaska Native ☐ Asian American ☐ Cape Verdian ☐ Caucasian
☐ Hispanic ☐ Nat. Hawaiian/ Pacific Islander ☐ Native American ☐ Un-Classified ☐ _____

Assistance: ☐ Blind/Sight Impaired ☐ Cane ☐ Cardiac ☐ CP ☐ Crutches ☐ Deaf/Hearing Impaired ☐ Dialysis
☐ Escort Required ☐ MS ☐ Parkinsons ☐ Oxygen ☐ Walker ☐ Wheel Chair ☐ Other

Head of Household: ☐ Yes ☐ No Do you live alone: ☐ Yes ☐ No **Allergies**: _____

Veteran: ☐ No ☐ Yes Indicate branch: _____ Permission to Use Photos: ☐ **Accept** ☐ **Declin**

Emergency Contact:

Name _____ Relationship: _____ City/Town: _____

Tel #: Home ( ) _____ Cell: ( ) _____ Work ( ) _____

Emergency Contacts: (Not living with you)

Name _____ Relationship: _____ City/Town: _____

Tel #: Home ( ) _____ Cell: ( ) _____ Work ( ) _____

Primary Care Physician: Medical Facility: _____ Doctors Name: _____

Telephone: ( ) _____Address: _____ City/Town _____