Mother DeVeaux Adult Day Care
528 Main Street Eastover SC
(803) 353-8475
"Treat Others as You Wish to be Treated"

Client Information

Name: _____

Seeking Adult Day Care Services M T W TH F (circle all that apply)

Requesting: __Full Day Services __Half Day Services __Drop in Services

Address: _____ City_____ State_____Zip Code_____

Home Phone Number: _____ Cell Phone: _____

Email Address: _____

Best Time to contact: Morning (9am- 12pm) Afternoon (1pm-4pm) Evening (5pm-7pm)

Medical History

Have the client been diagnosed with Alzheimer's/ Dementia by a medical doctor? YES or NO

Date of diagnosis _____ Provide the name of diagnosis _____

If client have not been diagnose, does he/she experience mental confusion or memory lost? Yes or NO. If Yes, please explain_____

_____

_____

Cardiovascular Problems: (Circle all that apply)

CVA/Stroke	**Parkinson's Disease**	**Diabetes**
TIA/Light Strokes	**Seizure History**	**Uses Oxygen**
MI/Heart Attack	**Sundowning Syndrome**	
High Blood Pressure	**Prosthesis**	
Blackouts	**Tobacco Use**	
Urinary Tract Infection	**Alcohol Use**	

Email form to cdeveaux@mdadc.org