



Safe Optimal Spaces

Client Information Form

Name _____

Are you the owner of the property? Yes No

Relation to owner _____

Address _____

Age of property _____

Contact Phone _____

Contact Email _____

Who lives in the property? What is their age?

<i>Resident</i>	<i>Age</i>



Please List all medical diagnoses that interferes with the resident's daily life? What medications address the diagnoses?

<i>Medical Diagnosis</i>	<i>Medication(s)</i>

Please describe any other medical history that is relevant.



In which areas of the property do you find difficult to navigate or perform daily tasks? Be as specific as possible.

<i>Area of Property</i>	<i>List Difficulties</i>

Please describe any other difficulties that are relevant.



What goals do you wish to achieve as you collaborate with Safe Optimal Spaces?

Can Safe Optimal Spaces take digital pictures of your property and save them in a secure software program and/or device?

Yes **No**

Can Safe Optimal Spaces display pictures of your property on their website for marketing purposes?

Yes **No**

Signature: _____



Safe Optimal Spaces

Notes (For Staff Use)
