

GOODLIVING
Intake Information Form

I. PERSONAL INFORMATION

Person's Full Name:	Form Completion Date:
Current Address:	
City:	Zip:
Date of Birth:	Primary Language:

PROVIDER CONTACT INFORMATION

Provider Name(s):	
Relationship to Participant:	
Home Phone:	Cell Phone for :
Other Phone:	Cell Phone for :
Address (if different from above):	
City:	Zip:
Email:	
Is face-to-face contact between staff and parent/provider/representative at picks-ups and drop-offs required?	
☐ NO ☐ YES (use space for additional notes)	

EMERGENCY CONTACT #1 (other than yourself)

Name:	
Relation to Participant:	
Home Phone:	Cell Phone:
Other Phone:	
Home Address:	

EMERGENCY CONTACT #2 (other than yourself)

Name:	
Relation to Participant:	
Home Phone:	Cell Phone:
Other Phone:	
Home Address:	

PARTICIPANT MEDICAL INFORMATION
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Primary Doctor:	Phone:
City:	Zip:
Health Insurance:	Policy & Group #:
Dentist:	Phone:
City:	Zip:
Dental Insurance:	Policy & Group #:

Hospital Choice:

Address:

City:

Zip:

Diagnosis:

Please identify the participants' disability and/or diagnosis or write in any other disability not listed:

- | | | |
|--|--|---|
| ☐ Attention Deficit Disorder | ☐ Learning Disability (specify) | ☐ Muscular Dystrophy |
| ☐ Asperger's Disorder | ☐ Mental Illness (specify) | ☐ Spina Bifida |
| ☐ Autism | ☐ Intellectual Disability, Mild | ☐ Spinal Cord Injury |
| ☐ Behavioral Disorder (specify) | ☐ Intellectual Disability, Moderate | ☐ Traumatic Brain Injury |
| ☐ Cerebral Palsy | ☐ Intellectual Disability, Severe | |
| ☐ Down Syndrome | ☐ Multiple Sclerosis | |

Other(s): _____

Medical Information:

Height: _____ Weight: _____

Please circle all that apply to participant:

- | | | |
|---|--|--|
| ☐ Allergies (specify) | ☐ Ear Tubes | ☐ Scoliosis |
| ☐ Arthritis G-Tube | ☐ Epilepsy | ☐ Shunt |
| ☐ Asthma | ☐ Glasses | ☐ Tracheotomy |
| ☐ Atlantoaxial Subluxation | ☐ Hearing Aid | ☐ Vision Impairment |
| ☐ Catheter | ☐ Hearing Impairment | ☐ Other: _____ |
| ☐ Diabetes | ☐ Heart Condition | |
| ☐ Diet Restrictions | ☐ High Blood Pressure | |

Please provide **specific** information for medical conditions we should be aware of (allergies, activity restrictions, etc.) _____

Does person have seizures? ☐ Yes ☐ No

If yes, what type?

- | | | |
|---|--|--|
| ☐ Simple Partial (focal) | ☐ Complex Partial (psychomotor) | ☐ Absence (petit mal) |
| | ☐ Clonic | ☐ Tonic |
| ☐ Tonic-Clonic (grand mal) | ☐ Atonic (drop) | ☐ Other _____ |

How often does participant have seizures? _____

Is there a protocol in place? ☐ Yes ☐ No

If Yes, please attach or used space below to provide specific protocol.

MEDICATION(s):

Please identify type, dosage, and time of any medication participant is currently taking:

TYPE	DOSAGE	TIME	WHY

II. Skill Assessment

Place a check next to each statement that applies to the participant. Please use the comment section to identify additional skills and/or areas of difficulty.

A. Dressing (putting on, taking off clothing)

- ☐ 1. Needs total physical assistance with dressing, undressing
- ☐ 2. Needs some physical assistance with dressing, undressing
- ☐ 3. Dresses, undresses with verbal directions
- ☐ 4. Dresses, undresses independently
- ☐ 5. Ties own shoelaces

Comments/Areas of difficulty:

B. Eating/Drinking

- ☐ 1. Takes pureed/soft foods from a spoon
- ☐ 2. Drinks from a cup with assistance
- ☐ 3. Drinks from a cup independently
- ☐ 4. Able to chew semi-solid food
- ☐ 5. Finger feeds if food is pre-cut
- ☐ 6. Able to use straw to drink
- ☐ 7. Able to grasp; use spoon
- ☐ 8. Able to unwrap, open containers
- ☐ 9. Able to open drink containers
- ☐ 10. Requires no assistance

Comments/Areas of difficulty:

C. Personal Care (toileting, washing)

- ☐ 1. Wears undergarment (Attends, Depends)
- ☐ 2. Shows discomfort in being wet
- ☐ 3. Indicates need to use toilet (gives advance notice)
- ☐ 4. Uses toilet with physical assistance (needs help wiping, etc.)
- ☐ 5. Uses toilet with verbal direction
- ☐ 6. Uses toilet independently
- ☐ 7. Washes hands with physical assistance
- ☐ 8. Washes hands with verbal direction

☐ 9. Washes hands independently

Comments/Areas of difficulty: _____

D. Communication

- ☐ 1. Communicates needs/wants with gestures or other non-verbal behavior
- ☐ 2. Communicates needs/wants with basic sign language
- ☐ 3. Communicates needs/wants with word symbol board or similar device
- ☐ 4. Communicates needs/wants with one or two statements
- ☐ 5. Communicates through partial or complete spoken sentences
- ☐ 6. Speaks clearly, can usually be understood
- ☐ 7. Able to recall and relate information accurately
- ☐ 8. English as primary language
- ☐ 9. Spanish as primary language
- ☐ 10. Bilingual; Indicate languages: _____

Comments/Areas of difficulty: _____

E. Receptive Language

- ☐ 1. Reacts or responds to various sounds
- ☐ 2. Able to distinguish between different sounds
- ☐ 3. Recognizes own name when called, spoken to
- ☐ 4. Responds appropriately to simple one-step directions (within capabilities)
- ☐ 5. Responds appropriately to two or three step directions (within capabilities)
- ☐ 6. Responds appropriately to directions given collectively to a small group of participants
- ☐ 7. Responds appropriately to directions given collectively to a larger group (6 or more)
- ☐ 8. Asks questions if unsure or needing more information

Comments/Areas of difficulty: _____

F. Mobility

- ☐ 1. Walks with full physical assistance
- ☐ 2. Walk with some physical assistance
- ☐ 3. Walks independently
- ☐ 4. Able to maintain balance over uneven surfaces
- ☐ 5. Walks up/down steps with physical assistance
- ☐ 6. Walk up/down steps independently
- ☐ 7. Able to walk continuously for 15 or more minutes
- ☐ 8. Able to maintain balance while running

Comments/Areas of difficulty: _____

G. Mobility for wheelchair/walker/crutch use (please circle which utilized)

- ☐ 1. While lying on a mat, is able to roll-over

- ☐ 2. Able to crawl or scoot short distance
- ☐ 3. Able to sit on floor/mat unsupported
- ☐ 4. Uses a manual wheelchair
- ☐ 5. Uses a motorized wheelchair
- ☐ 6. Uses a walker or crutches
- ☐ 7. Wheels self in wheelchair short distance
- ☐ 8. Wheels self in wheelchair longer distance
- ☐ 9. Able to transfer in/out of wheelchair with assistance
- ☐ 10. Able to transfer in/out of wheelchair independently
- ☐ 11. Able to negotiate minor barriers (doors, sloped surfaces, etc.)

Comments/Areas of difficulty: _____

H. Motor Coordination

- ☐ 1. Follows movement of objects with eyes
- ☐ 2. Able to reach toward objects
- ☐ 3. Able to touch, grasp objects
- ☐ 4. Able to release a grasped object when directed
- ☐ 5. Able to transfer object from one hand to another
- ☐ 6. Able to catch ball rolled
- ☐ 7. Able to catch ball bounced
- ☐ 8. Able to catch a ball tossed from a short distance
- ☐ 9. Able to kick a stationary ball
- ☐ 10. Able to kick a rolling ball

Comments/Areas of difficulty: _____

I. Social Skills

- ☐ 1. Demonstrates awareness of others
- ☐ 2. Responds to interaction of others
- ☐ 3. Aware of personal space, maintains appropriate distance
- ☐ 4. Will initiate interaction with others
- ☐ 5. Will play/interact cooperatively with another participant
- ☐ 6. Will play/interact cooperatively with a small group of participants
- ☐ 7. Able to identify and take responsibility for personal belongings
- ☐ 8. Aware of safety concerns when out in the community (traffic, staying with group, etc)
- ☐ 9. Manages frustration, controls anger
- ☐ 10. Able to adjust to changes in routine

Comments/Areas of difficulty: _____

What (if any) situations are likely to cause upset for the person? _____

Has this person ever shown aggression towards another person (peer, teacher, care giver, community member)? Please explain what this looks like (hitting, kicking, biting, pushing, etc).

Please identify any techniques used at home, school or other programs that successfully address the above challenges:

J. Activity Skills, Leisure Interests

- ☐ 1. Participation in activities requires much prompting/assistance
- ☐ 2. Participation in activities requires some prompting/assistance
- ☐ 3. Participation in activities requires little prompting/assistance
- ☐ 4. Will participate in an activity of interest; ☐ 5 min. ☐ 10 min. ☐ 15 min.
- ☐ 5. Understands directions (left, right, over, under)
- ☐ 6. Understands concepts of time
- ☐ 7. Understands basic number concepts
- ☐ 8. Able to count out one-dollar bills with assistance
- ☐ 9. Able to count out one-dollar bills independently
- ☐ 10. Able to use larger denominations of money with assistance
- ☐ 11. Able to use larger denominations of money independently
- ☐ 12. Able to count coins with assistance
- ☐ 13. Able to count coins independently
- ☐ 14. Able to read one word at a time
- ☐ 15. Able to read a basic level book
- ☐ 16. Able to write basic sentences
- ☐ 17. Identifies colors
- ☐ 18. Able to work a simple puzzle
- ☐ 19. Will indicate an activity preference
- ☐ 20. Will sit and watch a video/program for 30 minutes or longer

Comments/Areas of difficulty:

K. Swimming

- ☐ 1. Non-swimmer, requires individual attention in water
- ☐ 2. Non-swimmer, navigates shallow water independently
- ☐ 2. Puts face in water
- ☐ 3. Will submerge entire head under water
- ☐ 4. Can float on front
- ☐ 5. Can float on back
- ☐ 6. Swims short distance in shallow water
- ☐ 7. Able to swim in deep water

Comments/Areas of difficulty:

L. Transportation

- ☐ 1. General vehicle safety requires much prompting/assistance
- ☐ 2. General vehicle safety requires some prompting/assistance
- ☐ 3. General vehicle safety requires little prompting/assistance
- ☐ 4. Street and parking lot safety requires much prompting/assistance
- ☐ 5. Street and parking lot safety requires some prompting/assistance
- ☐ 6. Street and parking lot safety requires little prompting/assistance
- ☐ 7. Buckles seatbelt independently
- ☐ 8. Buckles seatbelt with verbal prompt(s)
- ☐ 9. Buckles seatbelt with hand-over-hand assistance
- ☐ 10. Able to sit safely in front seat
- ☐ 11. Able to sit safely in back seat
- ☐ 12. Requires child locks on doors
- ☐ 13. Requires window locks

Comments/Areas of difficulty:

M. Sensory Integration

- ☐ 1. Refuses or resists messy play
- ☐ 2. Is bothered by rough or itchy clothing
- ☐ 3. Has a high pain tolerance
- ☐ 4. Engages in behaviors that appear self-abusive (hitting head, pulling hair)
- ☐ 5. Avoids swinging, spinning or rotating (typical playground movements)
- ☐ 6. Seeks out/craves swinging, spinning, rocking or rotating motions
- ☐ 7. Has difficulty remaining still for short lengths of time
- ☐ 8. Frequently jumps, stomps, crashes into things
- ☐ 9. Seeks out deep pressure (asking for bear hugs, squeezes, bites hand/arm)
- ☐ 10. Often bumps into things/trips when walking
- ☐ 11. Frequently covers ears, is easily startled by loud sounds
- ☐ 12. Is easily distracted/bothered by ambient noise
- ☐ 13. Seeks out loud music/sounds
- ☐ 14. Has extreme food preferences and limited repertoire
- ☐ 15. Has difficulty with sucking, chewing, swallowing
- ☐ 16. Licks, tastes or chews on inedible objects
- ☐ 17. Easily nauseated by smells
- ☐ 18. Does not notice noxious odors
- ☐ 19. Is irritated by sunlight or bright lights
- ☐ 20. Is easily distracted by visual stimuli
- ☐ 21. Typically avoids eye contact

Comments/Areas of difficulty:

III. Participant Interests

(Check all that apply)

- ☐ Outdoor activities
- ☐ Pets/Animals

- ☐ Cards
- ☐ Games

- ☐ Exercise
- ☐ Shopping

- ☐ Travel/Trips
- ☐ Radio/Music
- ☐ Parties/Social
- ☐ Conversation
- ☐ Volunteer Work
- ☐ Individual Sports
- ☐ Team Sports

- ☐ Crafts
- ☐ Drawing/painting
- ☐ Reading
- ☐ Writing
- ☐ Drawing
- ☐ Fishing
- ☐ Hobbies

- ☐ Walking
- ☐ Watching TV
- ☐ Watching Movies
- ☐ Photography
- ☐ Video Games
- ☐ Gardening
- ☐ Relaxation/Meditation

What are the person's three favorite indoor activities?

What are the person's three favorite outdoor activities?

IV. Goals and Objectives

Based on your knowledge of the person, what goals and/or objectives do you think would help them to lead a more independent life? Your input would be most appreciated. We will work with the participant in the following areas during programs at Out & About to help meet these goals and objectives:

Language Skills:

Social Skills:

Cognitive Skills:

Motor Skills:

V. Conclusion: Please use the space provided to provide any other skills or challenges that the participant may face and/or concerns you might like to see addressed:

****Please print and sign your name below to indicate that you are the person responsible for the information provided in this form and that it is complete, current and accurate:**

Print name: _____ Relationship to Participant: _____

Signature: _____ Date: _____