R.O.O.C., Inc.
Intake Questionnaire

Name: _____ ☐Male ☐Female ☐Married ☐Single
Last First Middle Initial

Address: _____ _____
Street City State Zip County

This is ☐ my own home/apt. ☐ a family home Phone: (____)_____ Date of Birth: ___/___/___

Legal Guardian: ☐ Under age 18 ☐ Own ☐ Court Appointed (complete the following if checked):

Guardian Name: _____ Phone number: _____

Address: _____

Referring Agency: _____

Tell us about yourself:

What are things you like to do? _____

_____

What are some things you are good at? _____

_____

_____

What do other people like about you? _____

_____

_____

Have you ever participated in respite care before? ☐Yes ☐No If yes, what was the name of the agency and what did you do there?_____

_____

What type of respite will you receive (check all that apply)

☐ In home daytime ☐ In home nights ☐ In home weekend ☐ In home overnight

☐ Out of home daytime ☐ Out of home nights ☐ Out of home weekend

☐ Multi-consecutive days (i.e. vacation of hospitalization)

What do you want ROOC to help you do? _____

_____

What are things you do not like? _____

_____

What are the most important things we should know about you? _____

_____

Is there anything else we should know that will help us provide services to meet your needs? _____

_____

Who are the people you count on to help you make decisions? _____

MEDICAL INFORMATION

Who do we call in case of an emergency? _____ Phone _____

Who is your doctor? _____ Phone _____

Doctor's address: _____

What is your primary disability? _____

Do you take medication? ☐ Yes ☐ No If yes, please fill out the following chart:

Medication	Dosage	Purpose	Comment

Do you take medication by yourself? ☐ Yes ☐ No Do you need help with medication? ☐ Yes ☐ No

Do you have seizures? ☐ Yes ☐ No If yes, please describe: _____

Date of last seizure: ____/___/___ Approximate frequency: _____

Do you have allergies? ☐ Yes ☐ No If yes, please describe:_____

Do you have asthma? ☐ Yes ☐ No If yes, please describe: _____

Do you have any dietary restrictions? ☐ Yes ☐ No If yes, please describe: _____

Do you use any adaptive equipment? ☐ Yes ☐ No If yes, please describe: _____

Do you have any other special medical needs? _____

_____

EDUCATION INFORMATION

Level of Education Attained: ☐ Still in school ☐ Diploma ☐ G.E.D. ☐ Certificate ☐ Other

Name of School: _____

Last Date Attended: ___/___/___ City, State, Zip: _____

OFFICE USE ONLY

Intake Packet Sent: ___/___/___ **Intake Packet Received: ___/___/___**

Intake Meeting Date: ___/___/___ **First respite scheduled: ___/___/___**

Packet Contents

☐ Confidentiality and Disclosure

☐ Emergency Medical Authorization

☐ Consent for Services

☐ Acknowledgement of Rights/Problem Solving

☐ Notice of Privacy Practices Acknowledgement

Executive Director Signature and Date: _____