

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: _____