Member Intake Form

Date filled out: _____ **Desired Start Date:** _____

Circle one: **DTA** **RSP** **ATC** **HAB**

Member Name: _____ **Assist #:** _____

Nickname (s): _____

Date of Birth: _____ **Age:** _____ **Gender:** F____ M_____

DDD Diagnosis (list all):

_____

_____

_____

Resides with: Family Home_____ ADH_____ Group Home_____ IDLA_____

Member Address:_____
City State Zip

Home Phone: _____ Cell Phone: _____

Group Home information (if applicable):

Group Home Name: _____ Home Number**:** _____

Supervisor: _____ Work Number: _____

Email Address: _____

Guardianship: Parent _____ Public Fiduciary _____ Self _____

Guardian Name: _____

Address:_____
City State Zip

Home Phone: _____ Cell Phone: _____

Email Address: _____

Member Intake Form

DDD Support Coordinator Name: _____

Office Number: _____ Work Cell: _____

Email Address: _____

Emergency Contact Name: _____

Relationship: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

PCP or Health Care Facility:

_____

Address_____
City State Zip

Phone Number: _____

Primary Hospital:

_____

Address_____
City State Zip

Phone Number: _____

Primary Pharmacy:

_____

Address_____
City State Zip

Phone Number: _____

Health and Medical:

Current Medical Conditions:

_____

_____

_____

Seizures _____Yes _____No

_____Petit mal _____Completely controlled with medication

_____Grand mal _____Somewhat controlled with medication

_____Focal _____Not controlled with medication

Type_____ Frequency_____ Approx.

Duration_____

Unusual behavior **before** seizures (describe)

_____

_____

Unusual behavior **after** seizures (describe)

_____

_____

Recommended Response to Seizure Activity

_____

_____

Assistive Devices: **Yes _____** **No _____**

Hearing Aids _____ Vision Aids _____ Dental Appliances _____

Protective Devices needed:

_____

Purpose of device:

_____

Instructional Use

_____

_____

Other Individualized Health Care Routines

_____

_____

Medical History:

____Anemia	____Gall Bladder Problems	____Immune Disorder
____Asthma	____Gastritis	____Liver Disorder
____Blood Clots	____Head Trauma/Injury	____Migraine Headaches
____Cancer	____Heart Disease/Murmur	____Thyroid Disorder
____Chronic Bronchitis	____Hepatitis	____Ulcers
____Chronic Ear Infections	____High Blood Pressure	____Valley Fever
____Diabetes	____High Fever	
____Encephalitis	____Hydrocephalus	____None of the Above

Comments:_____

_____

_____

_____

Allergies: _____Yes _____No _____Unknown

List allergies: _____
_____

Allergy to food (specify):
_____
_____
___

Allergy to bee stings (specify):
_____
___

Allergy to medications (specify):
_____
_____
___

Food Intake

_____Independent _____Prompts _____Requires Help _____Full assistance

Independent with eating utensils _____Yes _____No **Sugar Allowed**

Requires limited assistance _____Yes _____No _____Yes _____No

Significant assistance needed _____Yes _____No

Consistency of food _____Normal _____Chopped _____Pureed

Choking hazard _____Yes _____No

Nutrition/ Diet:

Special Diet/Health Concerns:

_____

**A prescription filled out by the requesting medical professional needs to be provided to Stepping Stone, LLC for any diet or restrictions expected to be implemented within the day program.*

Beverages **Caffeine Drinks Allowed**

Independent with cup: _____Yes _____No Tea _____Yes _____No

Requires assistance/straw: _____Yes _____No Coffee _____Yes _____No

Significant assistance needed _____Yes _____No Soda _____Yes _____No

Independent obtaining/requesting beverages _____Yes _____No

**A prescription filled out by the requesting medical professional needs to be provided to Stepping Stone, LLC for any diet or restrictions expected to be implemented within the day program.*

Personal Care

	Toilet	Menses
Independent	_____	_____
Prompting	_____	_____
Requires Assistance	_____	_____
Significant Assistance	_____	_____

Mobility

_____ Independent
_____ Wheelchair
_____ Walker
_____ Crutches
_____ Fall Risk

Comments_____
_____
_____

Communication Skills:

Communication Modes

Verbal _____ Device _____ Sign _____ Gesture _____

Comments_____
_____
_____

Expressive Language:

_____ Articulate _____ Single Words _____ Asks for help

_____ Problems Articulating

Receptive Language:

_____Comprehends _____ Follows 3+step instructions _____Direct 1 step at a time

Comments_____
_____
_____
_____

Social/ Emotional Development

_____Relatively free from signs of problems

_____Interacts appropriately with caregivers

_____Interacts appropriately with peers

_____Interacts appropriately with animals

Fear of dogs _____Yes _____No

Expresses feelings _____Verbally _____Non-verbally

_____Initiates cooperative interactions

_____Usually even-tempered

_____Shows anger appropriately

_____Doesn't interact even when encouraged

_____Resists cooperation

_____Appears to have significant emotional problems

Staff Preference: _____Males _____Females _____No preference

Comments_____
_____
_____

Member obtains approved BTP: _____ Yes _____ No Exp. date: _____

*Attach copy of BTP to paperwork.

Behavioral Concerns

Describe Frequency

Aggression ____Yes ____No
_____

Self-Injurious ____Yes ____No
_____

Injurious toward others ____Yes ____No
_____

Property destruction ____Yes ____No
_____

Unusual repetitive behavior ____Yes ____No
_____

Self-stimulating (stimming) ____Yes ____No
_____

Running away ____Yes ____No
_____

Sexual acting out ____Yes ____No
_____

Other ____Yes ____No
_____

Comments_____
_____
_____
_____
_____

- ✓ **Members Likes** (Please add information to better care for our members)

Animals_____

Arts and Crafts_____

Board Games_____

Card Games_____

Community Activities_____

Computer_____

Dancing_____

Drawing/Coloring_____

Exceptional Interest_____

Movies_____

Music Favorites_____

Shopping/Stores_____

Snacks and Drinks_____

Sports_____

Subjects in School_____

Theater/Acting_____

TV Shows_____

Video Games_____

Word Search_____