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Supporting Families, Realizing Dreams.

Alta Mira Specialized Family Services
Family Support Services Intake

Initial SGF Hr Allocation: _____

Service: _____

Provider: _____

Participant Information			Date:
First Name:	MI:	Last Name:	SSN:
Address:	City:	Zip:	County:
Phone:	Date of Birth:	Age:	Gender: ○ F ○ M
Ethnicity:	Tribe or Nation:	Is Participant their own guardian: ☐	
Directions to home:			
Medicaid Waiver Eligible ☐	Medicaid #:		
Insurance Carrier:	Insurance Group:	Insurance Policy#:	
Case Manager:	Case Management Agency:		
Diagnosis:			

Special Needs – Choose all that apply							
Behavioral/Emotional	☐	Seizure Disorder	☐	Mental Health Issues	☐	Other Health Impaired	☐
Non-Ambulatory	☐	Hearing Impaired	☐	Communication Disorder	☐		
Speech Impaired	☐	Learning Disability	☐	Vision Impaired	☐		

Contact Information			
Contact 1	Name:		☐ Parent ☐ Guardian
Address:	City:	Zip:	Other Relationship:
Home Phone:	Cell Phone:	Email Address:	
Contact 2	Name:		☐ Parent ☐ Guardian
Address:	City:	Zip:	Other Relationship:
Home Phone:	Cell Phone:	Email Address:	

Emergency Information					
Name:		Relationship:			Phone:
Name:		Relationship:			Phone:
Physician:		Phone:			Hospital Preference:
Height:	Weight:	Eye Color:	Hair Color:	Blood Type:	Identifying Marks:
Allergies:			Allergic Reactions:		
Prescriptive Medications:			Significant Medical Condition:		
Cultural/Religious/Special Emergency Instruction:					

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Participant Full Name:	
Is Participant married? ☐	Does Participant have children? ☐
Please tell us about any major life events or changes which may affect Participant? (i.e. divorce, move, death)	

Others Living in Home		
Name:	Relationship:	Under age 18? ☐
Name:	Relationship:	Under age 18? ☐
Name:	Relationship:	Under age 18? ☐
Name:	Relationship:	Under age 18? ☐

External Family Contacts			
Contact 1	Name:		Relationship:
Address:	City:		Zip:
Home Phone:	Cell Phone:	Email Address:	
Contact 2	Name:		Relationship:
Address:	City:		Zip:
Home Phone:	Cell Phone:	Email Address:	

Visitation
Please list those who may visit or pick up Participant:
Please list those who may **NOT** visit or pickup Participant:
Please list other family, friends, or natural supports (church, neighbors, etc.):

Education and Work History		
Current School:	Next IEP meeting date:	
Teacher/Contact:	Grade:	Phone:
Does Participant enjoy and look forward to attending school?		
Has Participant ever been in an institution? ☐	Where?	When?
Does Participant have a job? ☐	Where?	How long?
Does Participant enjoy work? ☐	Job Coach name, if applicable	

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Medical Information and History	
Date of last physical exam:	Immunizations current: O Y O N
Tetanus Test: O Y O N Date:	TB Test: O Y O N Date:
General health history/hospitalizations:	
List any special health concerns which might require 911 emergency services or a doctor:	
Seizures - Please skip this section if not applicable	
Petit Mal ☐ Grand Mal ☐ Psycho Motor ☐ Other	Are seizures controlled by medication? O Y O N
Describe how long seizures typically last:	Describe what can trigger a seizure:
Describe seizure:	
Describe how care should be given **during** a seizure:	Describe how care should be given **after** a seizure:
During a seizure, at what point would you call for emergency assistance?:	
Individuals with a history of seizures can never be left alone while bathing. Please describe the best way to ensure privacy for your family member:	

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Participant Abilities and Routines

Language and Communication

Please describe key vocabulary (i.e. verbal, sounds, gestures, signs, eye gaze):

Expressive Language – how does the Participant communicate needs or wants?

Check all that apply:		Describe:
☐	Uses sounds	
☐	Uses gestures	
☐	Uses eye gaze	
☐	Uses sign language	
☐	Is verbal	
☐	Asks simple questions	
☐	Imitates phrases heard	

Receptive Language – how does the Participant communicate understanding?

Check all that apply:		Describe:
☐	Uses sounds	
☐	Uses gestures	
☐	Uses eye gaze	
☐	Uses sign language	
☐	Is verbal	

Is Participant able to make choices? ○ Y ○ N

How are choices/preferences communicated?

Are there any specific accommodations needed for effective communication with the Participant?

What is the Participant's preference for personal space and touch?

Learning Style

Check all that apply:		Effective Prompts:	Effective Motivators:
☐	Auditory (prompting, listening)		
☐	Visual (seeing, watching, copying)		
☐	Tactical (hands-on)		

Best time of day for learning:

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Motor

Level of Ability	N/A	Independently	With some assistance	Needs full assistance	Check assistance devices needed:			
Walking	○	○	○	○	☐	Cane	☐	Walker
Crawls or scoots	○	○	○	○	☐	Stroller	☐	Braces
Stands	○	○	○	○	☐	Wheelchair – electric	☐	Wheelchair – manual
Sits	○	○	○	○	☐	Ramps	☐	Safety bars
Able to pick up small objects	○	○	○	○	☐	Bath/shower chair	☐	Bath/shower lift
Able to point to familiar objects	○	○	○	○	☐	Eating utensils	☐	Assistive teaching

Other:

Eating

Level of Ability	N/A	Independently	With some assistance	Needs full assistance		Good	Fair	Poor
Eats with utensils	○	○	○	○	Participants appetite is:	○	○	○
Eats finger foods	○	○	○	○	Does the Participant have any food allergies: ○ Y ○ N			
Sits at table to eat	○	○	○	○	If yes, describe:			
Serves self	○	○	○	○				
Drinks from a cup or glass	○	○	○	○				
Drinks from a special cup	○	○	○	○				
Drinks from a bottle	○	○	○	○				

Where does Participant eat meals?

What is Participant's meal schedule?

Does the Participant have eating behaviors provider should be aware of?

Does the Participant have chewing or swallowing concerns provider should be aware of?

What are the Participant's favorite foods?

What foods does the Participant dislike?

What types of snacks should Participant be offered and how often?

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Sleeping

Participant sleeps in:	Bed		Crib		Other:				
Typical bedtime:	Preferences:		Nightlight		Door open		Door closed		
Sleeps with:									
Special sleeping position: Y N	If yes, please describe:								
Typical nighttime behaviors:	Sleepwalks		Nightmares		Sleeps through the night		Wakes during the night		
Describe bedtime routine:									
Nap time:					Nap length:				

Hygiene

Level of Ability	N/A	Independently	With some assistance	Needs full assistance	Preferences			
Bathing					Bathtub		Shower	
Adjusts water temperature								
Shampoos hair								
Shaves					Electric razor		Manual razor	
Washes face								
Washes hands								
Combs hair								
Brushes teeth								
Nail care								
Uses toilet								
Uses public restroom								
Menstruation								

Indicates need to use bathroom	Y N	Closes door when using toilet	Y N
Needs assistance with wiping	Y N	Washes hands after toilet	Y N
Wets the bed	Y N	Wears depends	Y N
Occasional accidents	Y N	Unusual toileting habits	Y N
Problems with constipation	Y N	Problems with diarrhea	Y N

Comments:

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Daily Living Skills				
Level of Ability	N/A	Independently	With some assistance	Needs full assistance
Makes bed	○	○	○	○
Puts clothes away	○	○	○	○
Cleans and straightens room	○	○	○	○
Picks up toys	○	○	○	○
Puts clothes in hamper	○	○	○	○
Uses washing machine	○	○	○	○
Uses dryer	○	○	○	○
Folds clean clothes	○	○	○	○
Helps with meal preparation	○	○	○	○
Uses stove	○	○	○	○
Uses microwave	○	○	○	○
Clears table	○	○	○	○
Washes dishes	○	○	○	○
Dries dishes	○	○	○	○
Uses dishwasher	○	○	○	○
Vacuums	○	○	○	○
Helps with yard work	○	○	○	○
Uses telephone	○	○	○	○
Walks to store	○	○	○	○
Money changing skills	○	○	○	○
Can tell time	○	○	○	○
Recognizes danger/safety signs:				
Traffic lights	○	○	○	○
Exit signs	○	○	○	○
Keep out/private property signs	○	○	○	○
Poison sign	○	○	○	○

Social Skills				
Level of Ability	N/A	Independently	With some assistance	Needs full assistance
Initiates activities	○	○	○	○
Participates in activities	○	○	○	○
Completes activities	○	○	○	○
Interacts in social settings:				
Only in familiar situations	○	○	○	○
In most situations	○	○	○	○
Shares well with others	○	○	○	○
Functions well in crowds: ○ Y ○ N				
Best way to give direction:				
Attention span:				
Special ethnic/holiday customs:				

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Leisure Activity Choices			
Favorite:			
Toys		Books, games, cards	
Music		Art and crafts	
Restaurants		Sports	
TV shows		Types of movies	
Leisure activities **NOT ALLOWED**:			

Individual Behaviors			
Causes harm to self by:	Hitting ☐	Biting ☐	Pulling hair ☐
	Scratching ☐	Punching ☐	Slapping ☐
Other:			
What triggers these behaviors? (i.e. physical, mental, environmental, frustration, need for attention)			
Is there anything you do to prevent these behaviors?			
What works/doesn't work?			

Causes harm to others by:	Hitting ☐	Biting ☐	Pulling hair ☐	Kicking ☐
	Scratching ☐	Punching ☐	Slapping ☐	
Other:				
What triggers these behaviors? (i.e. physical, mental, environmental, frustration, need for attention)				
Is there anything you do to prevent these behaviors?				
What works/doesn't work				

Bothers others by:	Arguing ☐	Complaining ☐	Yelling/screaming ☐
	Crying ☐	Hugging/touching ☐	Slapping ☐
Other:			
What triggers these behaviors? (i.e. physical, mental, environmental, frustration, need for attention)			
Is there anything you do to prevent these behaviors?			
What works/doesn't work?			

Repetitive Behaviors											
Pacing	☐	Rocking	☐	Hand movements	☐	Grinding teeth	☐	Odd faces/noises	☐	Attachment to objects	☐
Other:											
What triggers these behaviors? (i.e. physical, mental, environmental, frustration, need for attention)											
Is there anything you do to prevent these behaviors?											
What works/doesn't work?											

Social Behaviors							
Talking too loud	☐	Swearing	☐	Removing clothing	☐	Taking food without permission	☐
Standing too close	☐	Belching	☐	Telling untruths	☐		
Other:							
What triggers these behaviors? (i.e. physical, mental, environmental, frustration, need for attention)							
Is there anything you do to prevent these behaviors?							
What works/doesn't work?							

Stress/Frustration Behaviors									
Refuses to listen	☐	Aggressive	☐	Self-abusive	☐	Striking out	☐	Refuses to move	☐
Manipulates others	☐	Crying	☐	Steals	☐	Tantrums	☐		
Other:									
Are these behaviors predictable? ◯ Y ◯ N									
What are the consequences?									
What doesn't work?									
Comments:									

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Coping Skills			
Request time out/alone time	☐	Requests space	☐
Wants to talk or discuss	☐	Wants to call a parent	☐
Comments:			

Directions/Intervention/Rewards							
Time out	☐	Redirect activity	☐	Talk/discuss	☐	Ignore	☐
Talk firmly	☐	Take away toy or activity	☐	Direct eye contact	☐		
Rewards for good behavior:							
Comments:							

Sexuality			
Hugs or touches others inappropriately	☐	Lifts or touches others' clothing	☐
Needs reminding about appropriate behavior	☐	Undresses self in inappropriate places	☐
Is or can be easily taken advantage of sexually	☐	Knows appropriate sexual behavior	☐
Talks about getting married some day	☐	Talks about having a baby some day	☐
Is afraid of the opposite sex	☐		
Comments:			

Other Comments

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