

TAVON CENTER
Intake Assessment

Date: _____

CLIENT INFORMATION

Name: _____ Birth Date: ____/____/____

Address: _____ Height: _____ Weight: _____

City: _____ State: _____ Zip Code: _____ Age: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Gender: _____ Age: _____

Email: _____

Living Situation: _____ Legal Guardian: _____

Disability/Diagnosis: _____

Date of Diagnosis/Injury: _____

Optional- Ethnic Origin: (circle)

African American Asian American Caucasian Hispanic Native American Other: _____

EMERGENCY CONTACT

Name: _____ Relationship to Client: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: (home) _____

Phone: (cell) _____ Phone: (wk) _____

Email: _____

INSURANCE INFORMATION

For our insurance records, answers to the following questions are required:

Is the applicant covered by a care policy? (circle) YES / NO

Hospital of choice: _____

Primary Physician: _____ Phone: _____

Medical Insurance Policy: (carrier and type) _____

Policy Number: _____

PAYMENT

(circle one)

Private Pay

Respite

Medicaid Personal Care

SCHEDULE

What days and times do you plan to attend Tavon?

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	AM	AM	AM	AM
PM	PM	PM	PM	PM

What does your schedule outside of Tavon look like? This helps us understand attitude and energy level while at Tavon.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	AM	AM	AM	AM
PM	PM	PM	PM	PM

MOBILITY

Please answer the following questions (circle and explain answers as necessary):

Do you face a mobility challenge? (circle) YES / NO -- please check all that apply

Balance	Dexterity	Use Crutches
Coordination	Visual Impairment	Use Manual Wheelchair
Endurance/Fatigue	SCI	Use Cane
Hemiplegia	Use Power Chair	Other:
Walk Independently	Use Walker	

What equipment listed above do you use most often? _____

Do you have walking concerns? YES / NO _____

Do you require assistance on uneven, rough terrain? YES / NO _____

How far can you walk before resting? _____

Do you have a dominant side? LEFT / RIGHT

Wheelchair users please answer the following (circle where appropriate):

Do you use your chair: All the time Only when fatigued Only outside Only away from home

Do you operate the wheelchair independently? YES / NO

Transfers: No assist Minimal Assist Moderate Assist Total Assist Other: _____

Weight Shifts: YES / NO, required, how often? _____ Assistance/Props: _____

Please describe the functional limitations in your upper body and hands?

List any other adaptive equipment or mobility information: _____

TRANSPORTATION

How do you plan on getting to Tavon? (circle) Access Metro Own Transportation Other

Registered with Access? (circle) Yes No

Can be dropped off alone? (circle) Yes No

Pick up/drop off address the same? (circle) Yes No

DAILY LIVING SKILLS

Do you need assistance with any of the following? (check all that apply and explain if necessary)

Bathing/washing: _____

Dressing: _____

Teeth: _____

Hair: _____

Other: _____

Toileting: No assist Partial Assist Total assist: _____

Bladder needs: None Incontinent Needs Reminders Needs to go very often

Toileting schedule: _____

Other: _____

DIETARY/EATING

The lunches and snacks are designed to be wholesome and nutritious. Tavon will strive to meet all reasonable personal dietary requirements, while supplying appropriate food for the entire program. You may be asked to provide specialty foods to supplement the Tavon menu.

Dietary Needs: (circle) None Vegetarian Diabetic Modified Tube Thick Liquids

Other Restrictions (such as fluid): _____

History of choking? (circle) YES / NO Explain: _____

Food Allergies? YES / NO Explain: _____

Do you need assistance with eating? No Assistance Partial Assistance Total Assistance

Please explain: _____

What do you use at home? (special bibs, cups, utensils and plates) _____

COMMUNICATION

Style: (circle and explain as necessary) Verbal Sign Language Gestures Communication Board

Other: _____

Do you face restrictions in your ability to communicate? YES / NO _____

Can you understand what is said to you? YES / NO _____

Can you express your needs? YES / NO _____

Can you follow verbal directions given to you? YES / NO _____

Will you respect/follow directions given to you by a Tavon staff member (male or female)? YES / NO

Please explain: _____

BEHAVIOR

Tavon activities and outings are conducted in a group setting. Activities are designed to facilitate inclusion, interaction and teamwork.

Will participating in a group of five or more peers present any challenges for you? YES / NO

If yes, please explain: _____

Capacity to handle stress/change? (circle) YES / NO _____

History of violence to self or others? (circle) YES / NO

If yes, please describe last violent incident: _____

Typical sleep patterns: _____

Any history of wandering, combativeness, anxiety, restlessness, impaired judgment? _____

Please rate your short-term memory abilities (circle):

Average mild short-term loss severe short-term loss Extreme short-term memory loss

In a new situation do you: loose belongings get lost easily wander off run away

Anger issues: None Sometimes Often Severe Cause: _____

What helps you calm down? _____

Frustration: Never Occasionally Often Always Cause: _____

What helps you calm down? _____

Paranoia: Never Occasionally Often Always Cause: _____

What helps you calm down? _____

Depression: Never Occasionally Often Always Cause: _____

What helps you calm down? _____

Aggression: Never Occasionally Often Always Cause: _____

What helps you calm down? _____

_____ : Never Occasionally Often Always Cause: _____

Interventions that work: _____

Interventions to avoid: _____

EXPERIENCE

Have you ever participated in a day center? YES / NO Most recent year: _____ Where: _____

Why are you interested in participating in at Tavon? _____

In what activities are you currently engaged?

Are there activities that you have tried that don't work for you or that you have not enjoyed?
(please list below)

EDUCATION/WORK HISTORY

Name of School: _____

Academic Grade Level? _____ Emotional/Functioning Age: _____

Previous special education program and/or assistance in a classroom setting? YES / NO

Please describe below.

What type of work/volunteering are you currently doing or have done in the past?

EXPECTED OUTCOMES

1. What are your current therapy needs and goals?
2. What would you hope to see as an outcome from attending Tavon?
3. What approaches or techniques are successful?

****Please include any current evaluations that you think we may find useful with this form. (IEP, crisis plans)****

PREVIOUS THERAPIES

Date

Provider Name

Physical: _____

Occupational: _____

Speech: _____

Other Community Services: _____

GET TO KNOW YOU QUESTIONS

Do you like music? (circle) YES / NO What kind? _____

Do you like arts and crafts? (circle) YES / NO What kinds? _____

Do you engage in an exercise routine? _____

Which sports, if any, do you play or like? _____

Do you like to garden? (circle) YES / NO Previous Experience: _____

Do you like to be outdoors? (circle) YES / NO _____

Do you like to bake or cook? (circle) YES / NO _____

Jokes? (circle) I like to hear them I like to tell them

Stories? (circle) I like to hear them I like to tell them

Do you need downtime? When? How much? _____

Any other interests, strengths or skills? _____

Typical daily activities: _____

PART II: APPLICANT MEDICAL HISTORY

A. Personal History

Birth date _____ Age _____ Height _____ Weight _____

1. Do you use alcohol? _____ If yes, how often? _____
2. Do you use tobacco? _____ If yes, how often? _____
3. Have you been in counseling with a psychologist, psychiatrist or psychotherapist within the last year? YES / NO
4. Are you currently in treatment? (circle answer) YES / NO
5. Reason for treatment _____

B. Conditions and Symptoms – Do you or have you experienced any of the following? Write Y or N for each item.

High Blood Pressure	Communicable Disease
Heart Disease	Head Injury
Heart Murmur	Heatstroke
Family History of Heart Attack	Bladder Infection
Irregular Heartbeat	Difficulty Urinating
Tuberculosis	Kidney Problems
Recent exposure to active TB	Thyroid Problems
Positive TB skin test 32. Endocrine Problems	Active Hepatitis
Hearing Impairment	History of Hepatitis
Vision Impairment	Bleeding Disorder
Motion Sickness	Asthma
Sleep Walking	Diabetes
Broken Bones	Hypoglycemia
Neck Problems	Anorexia Nervosa/Bulimia
Back Problems	Other:
Arm or Shoulder Problems	Cancer
Leg, Knee or Ankle Problems	Skin Problems
Foot Problems	Frostbite
Currently Pregnant	Circulation Problems
Special Diet	Active Bedwetting
Learning Disability	Headaches
Anemia, Sickle cell trait or other blood condition	Stomach Ulcers
Medical Equipment Devices	Intestinal Problems
Other	Other

Do you currently or regularly have any of the following symptoms? Write Y or N for each item.

Chest Pain/Pressure	Heartburn
Heart Palpitations	Muscle Cramps
Unexplained Sweating	Intolerance of Cold Temps
Frequent Shortness of Breath	Intolerance of Warm Temps
Frequent Dizziness	PMS or Menstrual Problems
Frequent Fainting	Other:

If you answered “YES” to any of the above items, please explain below. Include the following information.

What specific symptoms are occurring?

How often symptoms occur?

How you care for the symptoms or condition?

How long symptoms last?

How symptoms or condition restricts your activity?

Date of last occurrence.

SYMPTOM:	DETAILED DESCRIPTION:

C. Seizure Specific Information

Have you been diagnosed as having a Seizure Disorder? (circle answer) YES / NO

If yes, what is the specific type of seizure? _____

Seizure Frequency _____ Current status (active or controlled) _____

Describe your seizure. Do you have any warning? What is the after effect of the seizure?

Describe specific care required in the event of a seizure and recovery time:

D. Medications

Please list any medications that you are currently taking, include over the counter medications.

Medication	Dosage	Condition	Side Effects

List any recent medication changes or behavior changes:

E. Allergies: List all allergies, including any to food or medications.

Allergy	Reaction	Medication Required	Additional Information

Any additional information that we need to know: (you can use back page as well)
