



LifePath Systems
MR SERVICES INTAKE FORM

MR CASE NUMBER

SERVICE GROUP

NAME Last First Middle DATE
ADDRESS

DOB:

AGE:

PHONE:() -
County of Residence

SSI# - -

LEGAL GUARDIANSHIP
PRIMARY LANGUAGE
SEX
ETHNICITY

BENEFITS: Check all that apply
SSI Medicaid#
SSD Mdicare#

REFERRAL INFORMATION:

Dose this individual have a diagnosis of:
Mental Retardation
Autism
PDD(Pervasive Developmental Disorder)
Other:

Estimated age when disability was identified:

Is there a family history of Mental Retardation or Mental illness? Yes No
Explain:

What is believed to be the cause of the disability?
genetic illness birth trauma accident unknown

At what age did individual walk?, Speak?, Complete toilet training?

What are the desired outcomes/supports for the individual?

REFERRANT:



FAMILY INFORMATION:

Mother's Name _____ Father's Name _____
Address _____ Address _____

Phone () _____ - _____ Phone: () _____ - _____

Primary Caretaker (if different from parents)
Name: _____ Relationship _____
Address _____

Phone () _____ - _____

Total number in household _____

Who is serving as the informant? _____

MEDICAL INFORMATION:

Medical/Health Problems:

Physicians:

Name: _____ Name: _____
Address: _____ Address: _____

Phone() _____ - _____ Phone() _____ - _____

Date of last physical exam: _____
Date of last dental exam: _____
Date of last immunization: _____

Is the individual taking any prescribed medications? _____ Yes _____ No

IF YES:

<u>MEDICATION</u>	<u>DOSAGE</u>	<u>FREQUENCY</u>	<u>REASON</u>	<u>DATE BEGUN</u>

Has individual previously had surgery? _____ Yes _____ NO

If yes, Describe _____



Has individual ever had seizures? _____ Yes _____ No

If yes, describe _____

Does individual currently have seizures? _____ Yes _____ No

If yes, describe _____

Does individual have any chronic illnesses? _____ Yes _____ No

If yes, explain _____

Does individual have any allergies? _____ Yes _____ No
(Food/Medication/Airborne)

If yes, describe _____

BEHAVEIOR PROBLEM: (Check those that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Self Injurious | <input type="checkbox"/> Self-Stimulatory | <input type="checkbox"/> Use of Illegal Drugs |
| <input type="checkbox"/> Tantrums | <input type="checkbox"/> Run-Away | <input type="checkbox"/> Excessive Alcohol Use |
| <input type="checkbox"/> Hitting (self or others) | <input type="checkbox"/> Set Fires | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Biting (self or others) | <input type="checkbox"/> Depressive | <input type="checkbox"/> Property Destruction |
| <input type="checkbox"/> Ritualistic | <input type="checkbox"/> Suicidal | <input type="checkbox"/> Doesn't relate well to peers |
| <input type="checkbox"/> Jeopardizes personal safety | <input type="checkbox"/> Promiscuity | <input type="checkbox"/> Doesn't follow rules |

Explain any items checked:

Has Individual been arrested? _____ Yes _____ No

If yes, please explain: _____

Is individual now on probation? _____ Yes _____ NO

If yes, Probation Officer's Name:

Name: _____

Phone: () _____ - _____



PSYCHIATRIC HISTORY: _____ Inpatient _____ Outpatient _____ Currently in therapy

Diagnosis _____
Facility/Counselor _____

Does individual have any sleep difficulties?

- ___ Wakes frequently
- ___ Cries in sleep
- ___ Wakes unusually early
- ___ Other

COMMUNICATION: (check all that apply)

EXPRESSIVE

- ___ Uses complete sentences
- ___ Speaks in phrases only
- ___ Speaks in single words only
- ___ Uses gestures and sounds
- ___ Uses sign language
- ___ No expressive communication
- ___ Uses augmentative communication device

ARTICULATION

- ___ Good
- ___ Fair
- ___ Poor

RECEPTIVE

- ___ Understands conversation
- ___ Responds to simple commands
- ___ Responds to name
- ___ No responses

Other: _____

VISION PROBLEMS

- ___ No problems
- ___ Near sighted
- ___ Far sighted
- ___ Astigmatism
- ___ Glaucoma
- ___ Cataracts
- ___ Wears glasses
- ___ Should wear glasses but doesn't
- ___ Blind
- ___ Other _____

HEARING PROBLEMS

- ___ No problems noted
- ___ Deaf
- ___ Hard-of-Hearing
- ___ Hearing Aid
- ___ Should wear hearing aid but doesn't
- ___ Other: _____

Adaptive equipment not previously noted: _____

Previous Services (Supported Employment, Residential, other MHMR Agency)

Name _____

Name _____

Address _____

Address _____

Date Attended ____/____/____

Dates Attended ____/____/____

THRU

THRU

____/____/____

____/____/____

