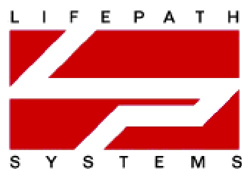

IDD SERVICES INTAKE FORM

____________________ ____________________ ____/____/____

Case Number **Service Group** **Date of Intake**

DEMOGRAPHIC INFORMATION

Name: ____

Last *First* *Middle*

Address:

____

____

____

County of Residence: _______________________

Phone: (_____) _____-________

Primary Language: _________________________

Legal Guardianship:

_____ Minor _____ Minor w/ Conservator

_____ Adult w/ Guardian _____ Adult, No Guardian

_____ Other: _____________________________________

DOB: ____/____/____

Age: _____________

Sex: _____ Male _____ Female

Ethnicity: _______________________

Birthplace (City): _______________________

Social Security #: _______-_______-_______

Benefits:

____ SSI ____ Medicaid #: ______________

____ SSD ____ Medicare #: ______________

____ Other: ______________________________

REFERRAL INFORMATION

The individual has a diagnosis of:

_____ Intellectual Disability

_____ Autism

_____ PDD (Pervasive Developmental Disorder)

_____ Other: ______________________________

_____ _____________________________________

_____ _____________________________________

Estimated age when the disability was identified: ______

What is believed to be the cause of the disability?

_____ Genetic _____ Illness _____ Birth Trauma

_____ Accident _____ Unknown

_____ Other: _____________________________________

Is there a family history of intellectual disability or mental illness? _____ **Yes** _____ **No**

If yes, explain: ____

____

____

At what age did the individual walk? _____ **Speak?** _____ **Complete toilet training?** _____

What are the desired outcomes/supports for the individual?

____

____

____

Who referred you to our services? ____ **Phone:** (_____) _____-________

FAMILY INFORMATION

Mother's Name: ______________________________
Address: ____________________________________
____
____
Phone: (_____) _____-________

Father's Name: _______________________________
Address: ____________________________________
____
____
Phone: (_____) _____-________

Primary Caretaker (*If different from parents*)
Name: _______________________________________
Relationship: _________________________________
Address: ____________________________________
____
____
Phone: (_____) _____-________

Emergency Contact (*If different from parents*)
Name: _______________________________________
Relationship: _________________________________
Address: ____________________________________
____
____
Phone: (_____) _____-________

Total number in the household: ________

Who is serving as the informant? ____

EDUCATIONAL HISTORY

The individual is receiving or has received services through:
_____ Early Childhood Intervention (ECI)
_____ Preschool Program for Children with Disabilities (PPCD)
_____ Special Education Self-Contained Classroom
_____ Special Education Resource Program
_____ Other: ______________________________
_____ _____________________________________
_____ _____________________________________

Has the individual finished school? _____ **Yes** _____ **No**
If yes, what was the age of the individual when he or she finished school? ________
If no, what school is the individual currently attending? ____

MEDICAL INFORMATION

Medical/Health Problems:
____
____
____
____

Physicians
Name: _______________________________________
Address: ____________________________________
____
____
Phone: (_____) _____-________

Name: _______________________________________
Address: ____________________________________
____
____
Phone: (_____) _____-________

Date of last physical exam: ____/____/____
Date of last dental exam: ____/____/____
Date of last immunization: ____/____/____

Height: ______________ **Weight:** ______________
Eye Color: __________ **Hair Color:** __________

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

Medication	Dosage	Frequency	Reason	Date Prescribed

Does the individual have any chronic illnesses or medical conditions? _____ **Yes** _____ **No**
If yes, explain: ____
____

Has the individual had surgery previously? _____ **Yes** _____ **No**
If yes, explain: ____
____

Does the individual have seizures currently? _____ **Yes** _____ **No**
If yes, explain: ____
____

Has the individual had seizures in the past? _____ **Yes** _____ **No**
If yes, explain: ____
____

Does the individual have any allergies (e.g., food, medications, and airborne allergies)? _____ **Yes** _____ **No**
If yes, explain: ____
____

Is the individual currently ambulatory (i.e., able to walk)? _____ **Yes** _____ **Yes, with assistance** _____ **No**

BEHAVIOR PROBLEMS *Check all that apply*

_____ Self-injurious
_____ Tantrums
_____ Hitting (self or others)
_____ Biting (self or others)
_____ Ritualistic
_____ Jeopardizes personal safety
_____ Self-stimulatory
_____ Run-away
_____ Set Fires
_____ Depressive
_____ Suicidal
_____ Promiscuity
_____ Use of illegal drugs
_____ Excessive alcohol use
_____ Stealing
_____ Property destruction
_____ Doesn't relate well to peers
_____ Doesn't follow rules

Explain any items checked:
____
____

Has the individual been arrested? _____ **Yes** _____ **No**
If yes, explain: ____
____

Is the individual on probation now? _____ **Yes** _____ **No**
If yes, who is the Probation Officer? ________________________________ **Phone: (_____) _____-________**

PSYCHIATRIC HISTORY

_____ Inpatient _____ Outpatient _____ Currently in Therapy _____ None/Unknown

Diagnosis **Facility/Counselor**

____
____
____

Does the 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
_____ Other: ______________________________

Articulation

_____ Good
_____ Fair
_____ Poor

Receptive

_____ Understands conversations
_____ Responds to simple commands
_____ Responds to name
_____ No responses

VISION PROBLEMS

_____ No problems noted
_____ 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 (*e.g., Supported Employment, Residential Services, Waiver Programs, and other MHMR Agencies*)

Name: ______________________________________
Address: ____________________________________
____
____
Begin Date: ____/____/____
End Date: ____/____/____

Name: ______________________________________
Address: ____________________________________
____
____
Begin Date: ____/____/____
End Date: ____/____/____

INDIVIDUAL PROFILE

Strengths:

Needs:

Likes:

Dislikes:

Personal goals:

Describe a typical day:

Morning	Afternoon	Evening

Signature of Informant **Date**

Signature of Individual Seeking Services **Date**

Signature of Intake Worker **Date**

08/20/13