RESSUCCESS
Instilling dignity and respect for greater independence

INTAKE ASSESSMENT FORM

Location Applying to _____

General Information

Applicant Name: _____

Address: _____

Phone: _____

DOB:_____ Sex: _____ Height: _____ Weight: _____

DESIRED START DATE: _____ Social Security #: _____ (optional)

Conservatorship

Does applicant have a Legal Conservator? Yes ☐ No ☐

If yes, what type of conservatorship? _____

(Conservatorship papers required if applicable)

Living Arrangements Check Applicable Box:

☐ With Parent(s) ☐ Other relatives ☐ Residential Care Home ☐ Supported Living

☐ Independent Living ☐ Other (Describe) _____

Current Residential Information

(Where does the applicant live? Fill out either Family or Agency section).

Family/Parent Name:	
Relationship to Applicant:	
Address:	
Phone:	Email:
Agency	
Agency Name:	
Address:	
Phone:	Email:
Dates of occupancy:	
Reason for leaving:	
Contact Person:	
Name:	Title:
Phone:	Email:

Family Composition

Name of Family or Household Member	Relationship to Applicant	Address/Phone /Email

Other Important Contacts

Name: _____

Address:_____

Phone: Home:_____ Work: _____ Cell:_____

Relationship to Applicant: _____

Name: _____

Address:_____

Phone: Home:_____ Work: _____ Cell:_____

Relationship to Applicant: _____

Name: _____

Address:_____

Phone: Home:_____ Work: _____ Cell:_____

Relationship to Applicant: _____

Languages Spoken/Understood by Applicant: (check all that apply)

☐ English ☐ Spanish ☐ Japanese ☐ Sign Language ☐ Filipino/Tagalog

☐ Mandarin ☐ Cantonese ☐ French ☐ German ☐ Italian

☐ Other Describe: _____

DAY SERVICES

CURRENT or MOST RECENT DAY PROGRAM/SCHOOL:

Name of Program: _____

Type of Program: _____

Address: _____

Phone:_____Email:_____

Dates of Admission: _____
(Admission) (Exit)

Reason for Leaving: _____

_____

Activities: _____

Days/Hours of Attendance: _____

Transportation used to and from program: _____

Contact Person: _____
(Name) (Title) (Phone #)

Other Agencies or Programs to which applicant is currently involved with:

_____

APPLICANT HISTORY: Previous Residential, Day Programs, Schools

Residential (previous)	
Name of residential program:	
Address:	
Phone:	Email:
Dates of occupancy:	
Reason for leaving:	

Day Program/School (previous)	
Name of day program/school:	
Type of Program:	
Address:	
Phone:	Email:
Reason for Leaving:	
Dates of Attendance	

What types of experiences have you had with other agencies? (positive or negative)

_____

_____

Employment
Has the applicant ever been employed? Yes ☐ No ☐
Employer:
Address:
Phone: Email:
Duties:
Wages:
Hours:
Reason for leaving:
Desire to obtain employment currently? Yes ☐ No ☐
If yes, what vocational areas are you interested in?

MEDICAL PROFILE

1. What is the applicant's developmental disability/psychiatric diagnosis?

_____

_____

_____

2. Medical diagnosis:

_____

_____

_____

3. Current Medications:

Name	**Date Started**	**Strength**	**Dosage**	**Reason for taking medication**

4. Precautions/Restrictions

Allergies:_____

_____

DietaryRestrictions:_____

_____

Other:_____

_____

5. Contagious Diseases/Conditions:

Skin Disease _____

Tuberculosis _____

Hepatitis B _____

Other _____

6. History of Immunizations

	Yes (Date)	No	Unknown	Any Reaction
Flu				
TB				
Hepatitis B				
Tetanus				

7. Seizure History

Does applicant have a history of seizures or compulsions? Yes ☐ No ☐

Type of Seizure Disorder: _____

Frequency of Seizures: _____

Date of Last Seizure: _____

Description of Typical Seizure: _____

_____

If applicant is taking medication for seizure control, are seizures:

Completely Controlled ☐ Partially Controlled ☐ Uncontrolled ☐

Any special instructions during a seizure? _____

_____

_____

8. Medical/Psychiatric Hospitalization History:

Name of Facility	Address	Dates	Age	Reason

9. Illnesses and Diseases: (History. If marked yes, please write age of onset and description)

Asthma	Yes ☐	No ☐	_____
Anemia	Yes ☐	No ☐	_____
Arthritis	Yes ☐	No ☐	_____
Bladder Control	Yes ☐	No ☐	_____
Cancer	Yes ☐	No ☐	_____
Diabetes	Yes ☐	No ☐	_____
Encephalitis	Yes ☐	No ☐	_____
Foot Problems	Yes ☐	No ☐	_____
Heart Disease	Yes ☐	No ☐	_____
High Blood Pressure	Yes ☐	No ☐	_____
Hepatitis	Yes ☐	No ☐	If Yes, Specify type: _____
Kidney Disease	Yes ☐	No ☐	_____
Meningitis	Yes ☐	No ☐	_____
Muscular Dystrophy	Yes ☐	No ☐	_____
Neurological	Yes ☐	No ☐	_____
Multiple Sclerosis	Yes ☐	No ☐	_____
Pneumonia	Yes ☐	No ☐	_____
Respiratory/Lung Disorder	Yes ☐	No ☐	_____
Stroke	Yes ☐	No ☐	_____
Ulcers/Colitis	Yes ☐	No ☐	_____
Other	Yes ☐	No ☐	_____

10. Tobacco/Alcohol Profile

Does the applicant smoke? Yes ☐ No ☐ Starting Age _____ Cigarettes per week _____

Does the applicant drink? Yes ☐ No ☐ Starting Age _____ Drinks per week _____

Ever abused drugs? Yes ☐ No ☐ When and What: _____
Name of drugs? _____
Addiction? Yes ☐ No ☐
Has applicant ever received treatment for any addiction? (Food, gambling, drugs, alcohol, internet).
If yes, when and where?_____

11. Criminal History

Has applicant ever been arrested for a misdemeanor or felony? Yes ☐ No ☐
If Yes, Describe: _____

12. Current Medical Providers (MD's and Therapist)

Name	Specialty
Address	
Phone #	Last Appointment

Name	Specialty
Address	
Phone #	Last Appointment

Name	Specialty
Address	
Phone #	Last Appointment

13. Special Needs (check appropriate box)

	Independent	Requires Assistance	Utilizes Adaptive Equipment (describe equipment used)	Other
Mobility			(Wheelchair/Walker/Crutches?)	
Vision				
Hearing				
Speech				
Feeding				
Repositioning				

Describe other special equipment: _____

_____

Developmental Profile

Activities of Daily Living Skills (ADLs)

(Check column that most accurately reflects applicant's level of skill in following areas)

	Does Independently	Needs Verbal Prompts	Needs Physical Prompts	Needs Full Assist/Cooperates	Need Full Assist/Resistant
Toileting					
Bathing					
Washing Hands					
Eating					
Dressing					

Independent Living Skills

(Check column which most accurately reflects applicant's level of skill in following areas)

	Independent	Assistance	Supervision	Total Support
Food Preparation				
Using Home Appliances				
Emergency Phone Calls				

Household Responsibilities: _____

_____

Travel Training Skills/Transportation:

How would consumer get to and from program?

☐ Mobility Plus ☐ First Transit ☐ A Car for Kids ☐ LINK

☐ Drop-off/pick-up ☐ Cab ☐ Public Transportation (independently)

☐ Drive his/her own car ☐ Walk/Bicycle

☐ Other (Describe) _____

Independent Living Skills:

Does Applicant:	YES	NO	Does Applicant:	YES	NO
Use Phone for Emergencies?			Use a Checking Account?		
Demonstrate Street Safety Skills?			Use a Savings Account?		
Have a driver's license?			Count Money?		
If yes, does applicant have access to a vehicle?			Make Purchases Independently?		
Use Public Transportation Independently?					

Behavior/Social Profile

1. Check behavior(s) that apply to applicant and explain

✓	BEHAVIOR	HOW OFTEN	DESCRIPTION
	Verbal Aggression		
	Physical Aggression		
	Self-Injurious Behavior		
	Property Destruction		
	Elopement/Wandering/Bolting		
	Inappropriate Touching		
	Inappropriate Sexual Behavior		
	Hyperactivity		
	Impulsivity		
	Extreme Mood Changes		
	Shy/Withdrawn		
	Resistive		
	Overly excitable		
	Phobias, Delusions, Hallucinations		
	Obsessions/Compulsions Rituals		
	Fabricates Stories/Lying		
	Bladder Incontinence		
	Bowel Incontinence		
	Smearing		
	Other:		
	Other:		
	Other:		

For items checked above, describe your most successful ways to respond:

_____

_____

_____

What situations result in anger, frustration, agitation, or undesirable behaviors? (Antecedents)

_____

_____

_____

2. Check area of social challenge that applies to applicant and explain:

✓	SOCIAL CHALLENGES	HOW OFTEN	DESCRIPTION
	Difficulty interacting with others		
	Does not maintain friendships		
	Cannot occupy self		
	Cannot control temper		
	Does not initiate conversation		
	Does not display affection appropriately		
	Does not greet people appropriately		

Please describe any social skill challenges and your most successful ways of responding:

_____

_____

_____

Behavior Management Approaches Currently Being Implemented

1. What are the most severe or intense behavioral challenges?

_____

_____

_____

2. Who implements behavior management approaches in the home/family?

_____

_____

3. What forms of approaches, reinforcements, and/or consequences are used?

_____

_____

4. Are they effective?

_____

_____

5. How does the applicant react to behavior management approaches?

_____

_____

APPLICANT PREFERENCES:

1. What activities does the applicant enjoy?

Indoors: _____

_____

_____

Outdoors: _____

_____

_____

Other hobbies/interests: _____

_____

_____

2. Please describe specific dislikes (as they may be related to the program):

_____

_____

_____

3. Applicant specific strengths:

_____

_____

4. Describe applicant's swimming ability:

_____

_____

5. Education (describe the applicant's interest and capabilities in each of the areas below):

Mathmatics:_____

_____

English:_____

_____

Computer:_____

_____

Science:_____

DESCRIPTION OF RELATIONSHIPS

Applicant and Parents:

_____

_____

Applicant and siblings or other family members:

_____

_____

Applicant and peers/friends/co-workers:

_____

_____

Applicant and job coaches/teachers/counselors:

_____

_____

If Applicant has always resided with family, please answer:
Has the family discussed Residential Placement? Yes ☐ No ☐
If yes, describe reasons/reactions to placement:
How could Residential Placement assist the family?
Has the applicant ever been separated from the family? Yes ☐ No ☐
Where?
When?
How long?
Reason:

If applicant is accepted to RES, what role would you play with the agency (fundraising, professional skills?)

_____

_____

Additional Information: (If there is any other information you feel important to share with RES?)

_____

_____

_____

_____

_____

_____

Name of Person Completing Form: _____

Relationship to Applicant: _____

Length of time known Applicant: _____

Date: _____

RES SUCCESS sincerely thanks you for your efforts in completing this intake form. If you have any questions regarding any of the questions on this form please contact Angela Lacativo Greene, Clinical Services Administrator (925) 229-8228.

Please return completed form:

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