Initial Intake Assessment

Client Name: **Date:**

Date of Birth: **NDIS No:** #

Parent(s)/Carer(s):

Disability/Diagnosis:

-
-
-
-
-

CURRENT SERVICES: (Please state all attending services and frequency of access)

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A. Social Skills

A. Client's/family's perception of client's *social* functioning.

B. When the client has a problem, who is the person he/she can most rely on? *(name, relationship)*

C. Dimensions of Client's abilities/preferences/barriers in forming and maintaining relationships *(e.g., isolated, likes daily contacts, prefers solitude, shy, unable to communicate)*

D. Please describe the roles and carer responsibilities of the caregiver: (*Describe dynamics, e.g., satisfaction of client and of caregiver, other responsibilities and strains on caregiver, evidence of burnout, strains on client, rewarding relationship for caregiver/client.*)

1. Dynamics of relationships with and among family, friends, and others *(e.g., neighbors, facility staff, past or present coworkers, church and other organizations, pets). Include pertinent information on cultural values, family roles, sources of strain and satisfaction.*

2. Significant history/changes in client's/family's social functioning.

B. Environment

A. Type of residence and Location:

B. If client lives with others, who is in the family, siblings, carers, head of household?

C. Is there any Environmental Supports required?

D. Is there anything in the family history, home and living, community or that challenges the individual or poses a risk to the client's physical, social, emotional, mental health, safety, or ability to attend to any portion of the individual's Activities of Daily Living (ADL's)?

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E. Please state concerns with access, ability, skill and attendance to Activities of Daily Living (ADL's)

☐ Access within Home	☐ Eating Area	☐ Lighting	☐ Shopping, access	☐ Transportation	
☐ Access, exterior	☐ Electrical Outlets	☐ Living Area	☐ Sleeping Accommodations	☐ Trash Disposal	
☐ Bathing facilities	☐ Fire Hazards/ No Smoke Detectors	☐ Locks/ Security	☐ Structural Integrity	☐ Ventilation	
☐ Cooking Appliance	☐ Heating	☐ Pests/Vermin	☐ Telephone	☐ Water/Plumbing	
☐ Cooling	☐ Laundry	☐ Refrigerator	☐ Toilet	☐ Yard or other area immediately out side of residence	☐ Other - Describe below

Comments:

F. Please list any and all comments which the participant experiences difficulties with accessing and attending to their daily environments. (Home/ School/ Community/ Play/ Transport).

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foundationofhopetherapies.com
admin@foundationofhopetherapies.com

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Intake Summary and Client Overvie

Inadequate, unsafe, or unhealthy conditions in client's environment (*space for comments/ explanations below if needed*.) If client is in a facility, record environmental issues/concerns under comments.

Comments:

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A. **Mental/Emotional Assessment**

A. Client's/family's perception of client's mental/emotional health

B. Mental, emotional, and cognitive problems, diseases, impairments and symptoms

Diagnosis/Symptoms	**Tick Areas of Concern**	**Notes (e.g., onset, severity, functional impact, history, untreated condition, needs professional assessment)**
Aggressive/abusive behavior		
Agitation/anxiety/panic attack		
Change in activity level (sudden/extreme)		
Changes in mood (sudden/extreme)		
Change in appetite		
Cognitive impairment/memory impairment **(SPECIFY)**		
Developmental disability/mental retardation **(SPECIFY)**		
Hallucinations/delusions		
Inappropriate affect (flat or incongruent)		
Impaired judgment		
Mental anguish		
Mental illness **(SPECIFY)**		
Orientation impaired: person, self, place, time		

Persistent sadness		
Sleep disturbances		
Substance abuse **(SPECIFY)**		
Thoughts of death/suicide		
Wandering		
Other:		
Other:		

B. Past and present hospitalizations/treatments for mental/emotional problems of participant *(Include patient, outpatient, therapy, and substance abuse recovery programs and names of current therapists or other involved mental health professionals.)* Please provide description these below:

C. Is there a history of mental illness or substance abuse in the client's family or household? Please explain below:

D. Strengths in the mental or emotional status of the client/family.

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E. **Physical Health**

A. Client's/family's perception of client's health status.

B. Physical health problems: diseases, impairments and symptoms:

Diagnosis/Symptom	Other - Specify	Notes (e.g., onset, severity, functional impact, history, untreated condition, needs professional assessment)
Arthritis/osteoporosis/gout		
Asthma/emphysema/other respiratory		
Bladder/urinary problems/incontinence		
Bruises		
Burns		
Cancer		
Dental Problems		
Diabetes		
Dizziness/Falls		
Eye Disease/Conditions		
Headaches		
Hearing difficulty		
Heart disease/angina		
Hypertension/high blood pressure		
Kidney disease/renal failure		
Liver diseases		
Malnourished/dehydrated		
M. Sclerosis/M.Dystrophy/Cerebal Palsy		
Pain		
Paraplegia/quadriplegia/spinal problems		

Parkingson's Disease		
Rapid weight gain/loss		
Seizures		
Sores **(Specify)**		
Speech Impairment		
Shortness of breath/persistent cough		
Stroke		
Other:		
Other:		

C. Does the client have any sensory or health problems that impair his/her ability to make or communicate responsible decisions? If so please explain in detail:

C. Medications *(prescription and over-the-counter)* and Treatments *(e.g., special diet, massage)*

Name	**Comments** *(dosage, compliance issues, side effects, other)*

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D. Other significant client/family history, including hospitalizations and outpatient procedures.

E. MedE. Medical Equipment/Assistive Devices/Supplies:

*(Record **U** if client uses it now, **N** if client needs it but does not have it.)*

Cane		Glasses		Ostomy/ Colostomy Bags	
Wheelchair		Dentures		Oxygen	
Crutches		Hearing Aid		Prosthesis	
Grab bars		Communication Devices		Other - Describe Below:	
Commode (seat/ bedside)		Diabetic Supplies			
Ramp		Incontinence Supplies			
Hospital Bed		Catheter			

F. If Medical Equipment/Assistive Devices/Supplies are prescribed, can you please describe any concerns, or add comments on the participants function and/or ability in using these items across all of the home, community, social, school/education and any other environment the participant attends across their usual life activities:

A. **ADL/IADL**

A. Client's/family's perceptions of the client's ability to perform the activities of daily living *(basic and instrumental)*

B. Review of activities of daily living (basic and instrumental)

ADL Tasks	**Help Needed**			**Need met?** 1 - Yes 2 - Partial 3 - No	**Comments:** (*e.g., who assists, equipment used, problems or issues for caregivers)*
	None	Some	Total		
Ambulation					
Bathing					
Dressing					
Grooming					
Toileting					
Transfers					
to/from bed					
to/from car					
IADL Tasks					
Home maintenance					
Housework					

Laundry					
Meal Preparation					
Money management					
Shopping/errands					

C. Is the client incapacitated, and without someone able, willing and responsible to provide assistance? Comments/Explanation:

D. Is the client able to read? ☐ Yes ☐ No

E. Is the client able to write? ☐ Yes ☐ No

F. Client/family strengths

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B. **Economic**

G. Client's/family's perception of client's financial situation and ability to manage finances.

H. Other resources *(e.g., Subsidized housing, Property, Medicare)*

I. Home/property ownership: ______________________________

J. Home and Living Supports – Plan of Home and Living Arrangements Ongoing/In Future:

K. Are there any problems/irregularities in the way the client's money is managed *(by self or others)*

If yes, please explain

☐ Yes ☐ No

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L. If expenses exceed income, what does the client do to manage?

M. Client/family strengths

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Formal Services Currently Received by Client. ***If none, check here:***

Service	Provider	Comments
Day Carer Support Provider(s)		
Night Carer Support Provider(s)		
CAP (Community Alternative)		
Case Management		
Counseling		
Employment Services		
In-home aide/		
Legal Guardian		
Meals		
Mental Health Services		
Nursing Services		
Public/Subsidized Housing		
Skilled Therapies (PT, OT, ST)		
Skilled Therapies (PT, OT, ST)		
Skilled Therapies (PT, OT, ST)		
Telephone Alert/Reassurance		
Transportation		
Other:		
Other:		

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WHODAS 2.0: Please rate participants Difficulty in the following tasks using the Key below:

Complex Score Key for IRT Analysis:

0 = No Difficulty; 1 = Mild Difficulty; 2 = Moderate Difficulty; 3 = Severe Difficulty; 4 = Extreme Difficulty or Cannot Do

Understanding And Communicating		Score
D1.1	Concentrating on doing something for ten minutes?	
D1.2	Remembering to do important things?	
D1.3	Analysing and finding solutions to problems in day-to-day life?	
D1.4	Learning a new task, for example, learning how to get to a new place?	
D1.5	Generally, understanding what people say?	
D1.6	Starting and maintaining a conversation?	
Getting Around		
D2.1	Standing for long periods such as 30 minutes?	
D2.2	Standing up from sitting down?	
D2.3	Moving around inside your home?	
D2.4	Getting out of your home?	
D2.5	Walking a long distance such as a kilometer [or equivalent]?	
Self-Care		
D3.1	Washing your whole body?	
D3.2	Getting dressed?	
D3.3	Eating?	
D3.4	Staying by yourself for a few days?	
Getting Along With People		
4.1	Dealing with people you do not know?	

D4.2	Maintaining a friendship?	
D4.3	Getting along with people who are close to you?	
D4.4	Making new friends?	
D4.5	Sexual activities?	
Life Activities		
D5.1	Taking care of your household responsibilities?	
D5.2	Doing most important household tasks well?	
D5.3	Getting all the household work done that you needed to do?	
D5.4	Getting your household work done as quickly as needed?	
D5.5	Your day-to-day work/school?	
D5.6	Doing your most important work/school tasks well?	
D5.7	Getting all the work done that you need to do?	
D5.8	Getting your work done as quickly as needed?	
Participation In Society		
D6.1	How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	
D6.2	How much of a problem did you have because of barriers or hindrances in the world around you?	
D6.3	How much of a problem did you have living with dignity because of the attitudes and actions of others?	
D6.4	How much time did you spend on your health condition, or its consequences?	
D6.5	How much have you been emotionally affected by your health condition?	
D6.6	How much has your health been a drain on the financial resources of you or your family?	
D6.7	How much of a problem did your family have because of your health problems?	
D6.8	How much of a problem did you have in doing things by yourself for relaxation or pleasure?	

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Difficulty over Previous 30 Days		
H1	Overall, in the past 30 days, how many days were these difficulties present?	
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	

Comments:

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ZARIT CARER BURDEN INTERVIEW

INSTRUCTIONS: The following is a list of statements, which reflect how people sometimes feel when taking care of another person. After each statement, indicate how often you feel that way; never, rarely, sometimes, quite frequently or nearly always. There are no right or wrong answers.

	Never	Rarely	Sometimes	Quite Frequently	Nearly Always
1) Do you feel that because of the time you spend with your relative you don't have enough time for yourself?	0	1	2	3	4
2) Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?	0	1	2	3	4
3) Do you feel angry when you are around your relative?	0	1	2	3	4
4) Do you feel that your relative's condition currently affects your relationship with other family members or friends in a negative way?	0	1	2	3	4
5) Do you feel tense when you are around your relative?	0	1	2	3	4
6) Do you feel your health has suffered because of your involvement with your relative?	0	1	2	3	4
7) Do you feel that you don't have as much privacy as you would like because of your relative?	0	1	2	3	4
8) Do you feel that your social life has suffered because you are caring for your relative?	0	1	2	3	4
9) Do you feel you have lost control of your life since your relative's illness?	0	1	2	3	4
10) Do you feel uncertain about what to do about your relative?	0	1	2	3	4
11) Do you feel you should be doing more for your relative?	0	1	2	3	4
12) Do you feel you could do a better job in caring for your relative?	0	1	2	3	4

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Please provide Information from collateral contacts, if appropriate.

Include date, name, relationship or position. Attach additional sheets if needed.)

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Additional notes (optional) *This space provided for any relevant information that needs documentation and does not fit elsewhere on the tool.*

Summary of Findings - Including strengths and problems

0481 716 504
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admin@foundationofhopetherapies.com

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Documentation of eligibility for specific services:

Next step(s) *(Check all that apply)*

☐ Close case	☐ Develop Goals/Service Plan	☐ Transfer Case
☐ Complete FCA Report	☐ Make Referral to Another Agency	☐ Other - Explain below

If other, explain:

Parents/Carers Signature: ________________________________ **Date**:

FOHT Representative: ___________________________________ **Date**: