

NEW CLIENT INTAKE FORM Referral source and date:

--

Thank you for your interest in our services and supports to assist you to engage in interesting and meaningful activities in your community. In order to meet your individual needs, it would be helpful to have some information about you, including your contact information, accommodation requirements, background, and goals for the future. Please let us know if you require any assistance to complete this form. It can be downloaded and completed by tabbing between the fields. You can also print it and complete it in writing.

Full (legal) first name		Last name	
Preferred first name		Pronunciation	
Address	Postal code	City	
Home phone Messages: Yes <input type="checkbox"/> No <input type="checkbox"/>		Cell phone Messages: Yes <input type="checkbox"/> No <input type="checkbox"/> Text: Yes <input type="checkbox"/> No <input type="checkbox"/>	
E-mail address			
Preferred method of communication	Home phone <input type="checkbox"/> Cell phone <input type="checkbox"/> E-mail <input type="checkbox"/> In writing - paper documents <input type="checkbox"/>		
Emergency contact	Cell phone		
Relationship	Home phone		
Do you identify as a person with a disability ? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, it would be helpful for us to have information about your condition as it relates to your functional abilities and accommodation requirements. To protect your privacy, we do not require a diagnosis of your health condition or any details regarding your medical history. However, we encourage you to discuss any new or unaccustomed activities with your health care providers to ensure that it is a good fit for you.			
Nature of your disability	Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Episodic/recurring <input type="checkbox"/>		
ACCOMODATION REQUIREMENTS			
Limitations – activities that you generally avoid but could perform on an occasional basis			
Restrictions - activities that you must avoid and cannot perform due to your disability			
Please describe any triggers that may cause your condition to worsen.			
What specific actions may be required in case of emergency?			
Environmental needs			
Adaptive equipment			
Preferred schedule	Monday: AM <input type="checkbox"/> PM <input type="checkbox"/> Tuesday: AM <input type="checkbox"/> PM <input type="checkbox"/> Wednesday: AM <input type="checkbox"/> PM <input type="checkbox"/> Thursday: AM <input type="checkbox"/> PM <input type="checkbox"/> Friday: AM <input type="checkbox"/> PM <input type="checkbox"/> Saturday: AM <input type="checkbox"/> PM <input type="checkbox"/> Sunday: AM <input type="checkbox"/> PM <input type="checkbox"/> Total hours per week:		

Work experience	
Volunteer experience	
Hobbies and interests	
Skills and abilities	
Future goals	
Knowledge / skills you would like to gain	
Challenges or difficulties you have recently or are currently facing	
Achievements or challenges you have overcome	

We appreciate you taking the time to complete this form so we can better understand your needs and accommodation requirements. If you would prefer to complete your intake in person or have any question about the intake process, please contact us directly by phone or email. Any personal information gathered from you as a client will be kept in the strictest confidence and will not be shared without your consent.