Speaking On The Spectrum Supports ABN 73 676 771 396

Client Intake Form

Speaking On The Spectrum Supports appreciates that everyone is unique, please help us to get to know you by answering the following:

Client Details	
Client First Name:	
Client Last Name:	
Client Date of Birth:	
NDIS Number:	
NDIS Funding Type:	☐ Agency Managed (**NDIS**) ☐ Self Managed ☐ Plan Managed
Provide Plan Manager (if applicable) see NDIS Funding Type	
Address	
Contact Number	
Email	
Preferred method of contact	☐ Phone ☐ Email ☐ SMS ☐ Mail

Representative or Emergency Contact Details	
First Name	
Last Name	
Relationship to Client	
Address	
Phone Number	
Email	
Preferred method of contact	☐ Phone ☐ Email ☐ SMS ☐ Mail

About you	
Living Situation	☐ Own home (alone) ☐ Own Home (with family) ☐ Supported Accommodation ☐ Temporary ☐ Other: _____
Aboriginal or Torres Strait Islander descent?	☐ Yes ☐ No
Does the Client have a current Behavioural Support Plan	☐ Yes ☐ No
Primary Formal Diagnosis	
Secondary Formal Diagnosis	
Do you have any allergies? If yes please provide below	
Please provide all medical diagnoses and medicine that may affect the support provided	
Please provide the name and contact number for Client's Doctor	
Please disclose any legal issues that may affect service eg. Apprehended Violence Order	

Consent	
Do you consent to participating in and use of...	☐ Photos for Goal Data ☐ Photos for Social Media ☐ Photos for the website ☐ Participating in audits in respect of our business by the NDIS Commission and its auditors ☐ Your personal information being recorded in audio and/or visual format ☐ None of the above

Communication	
Type	☐ Verbal ☐ Non-Verbal ☐ Communication aids required ☐ Other: _____
Are you of a culturally or linguistically diverse background?	☐ Yes ☐ No Details:
Do you have any culture, diversity, values and beliefs of which we should be aware?	☐ Yes ☐ No Details:
Languages Spoken	☐ English ☐ Other: _____
Is an Interpreter required?	☐ No ☐ Hearing Impaired ☐ Language

Dietary Requirements		
I have the following allergies/intolerances and my favourite food is...		
No dietary requirements	☐ Yes	☐ No
Vegetarian	☐ Yes	☐ No
Vegan	☐ Yes	☐ No
I am allergic to (please list)		
I am unable to eat (sensory/intolerances)		
My favourite food is...		
Speaking On The Spectrum Supports can assist me during mealtimes by...		
☐	I can identify what foods are safe for me to eat (if required due to allergy or dietary requirements).	
☐	If I have a food allergy, I have provided Speaking On The Spectrum Supports with a management plan.	
☐	If required I will bring any medications to assist me with my allergy and have completed the relevant medical forms	
☐	I prefer to provide my own food and will do so	

Practical Support Needs			
Check the boxes which best represent you and your support needs…			
Behaviour	**I can do independently**	**I need a little help**	**I cannot do independently**
Traffic awareness	☐	☐	☐
Staying with the group	☐	☐	☐
Communicating appropriately	☐	☐	☐
Looking after property	☐	☐	☐
Being aware of personal space	☐	☐	☐
Keeping my hands to myself	☐	☐	☐
Travelling safely in a car	☐	☐	☐
Following instructions	☐	☐	☐
Swimming and safety around water	☐	☐	☐
I can handle my own spending money	☐	☐	☐
I am comfortable in my sleeping routine	☐	☐	☐
Speaking On The Spectrum Supports can assist me by…			
☐	I have provided Speaking On The Spectrum Supports with any relevant behaviour plans for assisting me when required.		

A bit about you and your goals		
To help us understand you better, please fill the below:		
💪	My strengths are (what I am good at)...	
👍	I like...	
👎	I don't like… (please include any sensory considerations)	
🙂	You will know when I am happy by...	
😔	You will know when I am unhappy by...	
💬	I prefer to communicate by...	
🙂	What are your goals for the next 12 months?	
🙂	How have these goals changed since your previous Support Plan (if applicable)	
👍	How do your existing support from us or other providers help achieve desired outcomes? Is there any opportunity to use less intrusive options, in accordance with contemporary evidence-informed practices that meet participant needs and help achieve desired outcomes.	

Mental Health			
I have/experience...			
☐	Depression	☐	Anxiety
☐	Psychosis	☐	Schizophrenia
☐	Bipolar	☐	Other
I would like Speaking On The Spectrum Supports to help me manage this by...			
My triggers may include...			
I am supported/linked with the following organisations who assist me… (Please supply relevant management plans.)			
☐	I have received medical support to assist me and Speaking On The Spectrum Supports has a copy of any relevant management plans to help me manage.		

Physical Health			
I have...			
☐	Diabetes	☐	Sleep Apnoea
☐	Epilepsy	☐	Dietary Needs
☐	Asthma	☐	Blood Disorders
☐	Visual Impairment	☐	Hearing Impairment
☐	Cognitive Impairment	☐	Heart Conditions
☐	Allergies to:		
☐	Other:		
I am on the following medications:	List of medications:		
I would like Speaking On The Spectrum Supports to help me manage this by...			
Please supply Speaking On The Spectrum Supports with relevant management plans prior to commencing programs.			

Health Requirements

Activity	Tick one	Condition	Outline condition, treatments, aids/assistance required, from whom and when
Continence	☐	Continent with regular bowel and bladder action	
	☐	Constipation, diarrhoea or incontinence (using medication, supplements, pads)	
	☐	Medical interventions (catheter, stoma bag)	
Skin Integrity	☐	No skin problems	
	☐	Some skin problems (rash, skin treatments)	
	☐	Pressure areas (currently have, at risk, or had in past)	
Swallowing	☐	No swallowing issues	
	☐	Some swallowing problems (choking, coughing during normal meal, reduced appetite)	
	☐	Major swallowing difficulties (modified diet, feeding tube)	
Health professionals	☐	Have had a GP check up in the last 12 months	
	☐	See a specialist regularly	
	☐	Have a case manager/support coordinator	
Muscular pain	☐	No pain	
	☐	Moderate pain	
	☐	Severe pain	
Nerve pain	☐	No pain	
	☐	Moderate pain	

Activity	Tick one	Condition	Outline condition, treatments, aids/assistance required, from whom and when
	☐	Severe pain	
Falls	☐	No falls in past 12 months	
	☐	Less than 3 falls and no serious injury from a fall in past 12 months	
	☐	More than 3 falls or a serious injury from a fall in the past year	
Muscular issues (other than pain)	☐	No problems	
	☐	Some muscle weakness, tremor, spasms, spasticity or problems with balance	
	☐	Serious muscle weakness, tremor, spasticity or problems with balance	
Other health concerns	☐	Fatigue	
	☐	Visual disturbance	
	☐	Temperature intolerance	
	☐	Other comorbidities	

Social Requirements

Activities	Outline how you want to do this activity	Provide details of the activity, the time spent, the assistance required, from whom and when (including vouchers)
Example: I love cooking	• I like to watch cooking shows on TV • I like to buy good cook books • I like to prepare my own meals • I like to attend cooking classes regularly	• I need a TV in my room with good reception. • I need a computer/tablet and high speed internet or Wi-Fi to buy books online. • I would like to have access to a kitchen to prepare my own meals 2 x per week • I need a maxi taxi and carer/staff member to take me to cooking classes once a month
Family:		
Hobbies & Interests:		
Religion & spirituality		
Outings: E.g. theatre, cafes, exhibitions, drives, group activities		
Computer: E.g. games, shopping, education, bookings		
Employment: Education, Volunteering		
Sports:		

Activities	Outline how you want to do this activity	Provide details of the activity, the time spent, the assistance required, from whom and when (including vouchers)
Music: Likes, dislikes		
Movies/TV: Likes, dislikes		
Well-being: E.g. exercise, gym, swimming, massage, yoga, meditation etc...		
Food and alcohol: Likes, dislikes, diets		
Sex and intimacy		
Other:		

Behavioural Requirements

Issue	Tick one	Assistance I need	Outline the issue, aids, assistance and management strategies required
Communication	☐	No assistance required (including independent use of aids and adaptive technology)	
	☐	Some assistance required (prompting, assistance with aids)	
	☐	Assistance always required	
Memory problems Confusion	☐	No	
	☐	Yes	
Concentration problems	☐	No	
	☐	Yes	
Planning problems	☐	No	
	☐	Yes	
Spiritual needs	☐	No	
	☐	Yes	
Mood	☐	Mostly positive	
	☐	Experience sadness, anxiety or emptiness around 50% of time	
	☐	Feelings of anxiety, sadness or emptiness lasting most of the day, nearly every day	
Decision Making	☐	No help needed	
	☐	Need some help	
	☐	Not able to make any decisions	

Issue	Tick one	Assistance I need	Outline the issue, aids, assistance and management strategies required
Do you have a Will?	☐	No	
	☐	Yes	
Do you have an Enduring Power of Attorney or Guardian?	☐	No	
	☐	Yes	
Do you have an Advanced Care Plan?	☐	No	
	☐	Yes	

Behavioural Routines

What things are important for people to understand about you when caring for you?	Provide details	Outline how you like this to be managed
Who makes the decisions?		
What routines do you have?		
What makes you happy?		
What helps you relax?		
What causes you stress?		
What makes you frustrated?		
What makes you angry?		
Other		

Matching

We recognise the significance of matching the right staff member to meet your needs and consider a number of factors such as personality, language, culture and skill requirements.

We encourage and support you to be involved in the process of matching your needs with the right staff. We can also support you to access an advocate of your choice to support you in this process.

Preferred Workers Characteristics	Details	Notes in relation to potential Workers
Gender	☐ Male ☐ Female ☐ No preference	
Personality type		
Languages spoken		
Culture or religion		
Specific needs, skills and knowledge required		
Do you require any intrusive support?		
Do you have any specific needs which require monitoring and/or daily support by appropriately trained Workers?		
What specific training may be required to provide support and services to you?		

Consent

Please sign below to indicate your consent and agreement to the details set out in this client intake form above.

If you do not consent/agree, please specify:

Signed for and on behalf
of **Speaking On The Spectrum Supports Pty Ltd**
ABN 73 676 771 396 (**Speaking On The Spectrum Supports**), by:

……..…….. Date: ……/……/……..
Signature

……..……..
Name (please print)

Signed by the **Client**:

……..…….. Date: ……/……/……..
Signature

……..……..
Name (please print)

Signed by the **Representative**:

……..…….. Date: ……/……/……..
Signature

……..……..
Name (please print)