(Attach Photo Here)

2019-2020 Kulanu Ba'aretz ***Intake Questionnaire***

Participant's Legal Name: _____ Gender: ☐M ☐ F
(FIRST) (MIDDLE) (LAST)

DOB: _____/_____/_____ Email: _____ Cell: _____

Passport No.: _____ Passport Exp. Date: _____/_____/_____ SS No.: _____

Home Address: _____
(STREET) (CITY) (STATE) (ZIP)

Program Option: ☐ Two-Month (10/27/19 to 12/22/19 @ 57 days) ☐ Three-Month (10/27/19 to 1/12/20 @ 77 days)

A non-refundable processing fee of $75.00 payable to Kulanu Academy must accompany this questionnaire. All submissions should be directed to Cheryl Baruch via email or regular mail as follows: Cheryl@kulanukids.org or Kulanu, P.O. Box 305, Cedarhurst, New York 11516.

NOTE: If needed, please use additional paper to record information and submit it with your completed questionnaire.

FAMILY INFORMATION:

Father

Name: _____

Address: _____
(only if different than participant)

Home Phone: _____

Cell Phone: _____

Email: _____

Employer: _____

Nature of Business: _____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Religious background: ☐ Conservative ☐ Modern ☐ Orthodox ☐ Unaffiliated

Synagogue affiliation: _____

Mother

Name: _____

Address: _____
(only if different than participant)

Home Phone: _____

Cell Phone: _____

Email: _____

Employer: _____

Nature of Business: _____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Religious background: ☐ Conservative ☐ Modern ☐ Orthodox ☐ Unaffiliated

Synagogue affiliation: _____

PARTICIPANT INFORMATION:

- ***MENTAL & PHYSICAL HEALTH***

PSYCHOLOGICAL and/or MEDICAL EVALUATION: ☐ YES ☐ NO If yes, provide a current copy

Do you have any food allergies? ☐ YES ☐ NO If yes, please explain: _____

_____

Do you carry an Epi Pen? ☐ YES ☐ NO

Do you use any walking aids, wheelchairs or other adaptations? ☐ YES ☐ NO If yes, please explain:

_____

Do you have any existing medical or mental health condition we should be aware of? ☐ YES ☐ NO

If yes, please explain: _____

List ALL current prescription medications, as follows:

Prescribed Medication	**Prescribed Dosage**	**How often** ***(1x/2x)***	**Time of day** ***(am/pm)***	**With food?**

- ***EDUCATION & EMPLOYMENT***

IEP/IESP: ☐ YES ☐ NO If yes, provide a current copy

LIFE PLAN (OPWDD): ☐ YES ☐ NO If yes, provide a current copy

Current school/program placement? _____

What academic accommodations have been helpful to you in the past? _____

_____

Are there particular subject areas that are more difficult for you than others? ☐ YES ☐ NO If yes, please explain:

_____

Will you be taking any assistive technology with you? ☐ YES ☐ NO If yes, please explain: _____

_____

Please describe any difficulties you have with executive functioning skills *(starting/prioritizing tasks, time management)*:

_____

Employment history? ☐ YES ☐ NO If yes, provide company name, title and dates of employment:

_____

_____

❖ *HOME LIFE*

Who lives with you at your home? _____

Siblings? ☐ YES ☐ NO If yes, provide details *(name, gender & age)* _____

_____

Religious background? ☐ Conservative ☐ Modern ☐ Orthodox ☐ Unaffiliated

What dietary restriction do you observe? ☐ Kosher ☐ Vegetarian ☐ Gluten Free ☐ Vegan ☐ None ☐ Other

_____

What are your hobbies/extracurricular activities: _____

_____

How have you made friends in the past? _____

Do you have an exercise regimen? ☐ YES ☐ NO If yes, please explain: _____

_____

Have you ever attended a sleep away camp or program? ☐ YES ☐ NO If so, provide details: _____

_____

Have you previously flown on an airplane? ☐ YES ☐ NO

Do you have difficulties in any of the following areas? *(Check all that apply and explain in detail)*:

☐ Dressing ☐ Eating ☐ Bathing ☐ Grooming ☐ Toileting ☐ Bed Wetting

_____

❖ *BEHAVIORS*

How comfortable are you in group or social settings?_____

Are there any specific conditions that make group settings more manageable? _____

_____

What strategies do you use to adapt to uncomfortable group settings? _____

_____

What is your daily routine? For example, what time to you wake up, go to sleep? _____

_____

How hard is it to maintain your routine while away from home? _____

How do variations in routine affect your mood? _____

_____

❖ ***BEHAVIORS*** ***(continued)***

How do you approach new situations and meeting new people? _____

_____

Do you have any unusual preoccupations or actions that you do repeatedly? ☐ YES ☐ NO If so, describe the behavior:

_____

Do you have a narrow and intense focus on a particular topic? ☐ YES ☐ NO If so, describe the behavior:

_____

How do you approach speaking in public? _____

Do you experience crisis episodes, including panic/anxiety attacks? ☐ YES ☐ NO If yes, please explain in detail:

_____

Can you recognize when you are in crises? ☐ YES ☐ NO

What strategies have been effective for you in managing crises? _____

_____

Do you have any of the following sensory concerns? *(Check all that apply and explain in detail)*:

☐ Sound ☐ Light ☐ Touch ☐ Food ☐ Smell ☐ Texture

_____

What coping mechanisms or strategies do you use for any sensory concerns? _____

_____

Please tell us anything else that we need to know to better accommodate your needs:

_____

_____

_____ _____

Participant Signature *Date*

_____ _____

Parent/Guardian Signature *Date*

FOR OFFICE USE ONLY

$75.00 non-refundable processing fee: ☐ check enclosed ☐ credit card payment

Credit Card: ☐ AM EX ☐ VISA ☐ Discover ☐ MasterCard Exp. Date _____

Card Holder: _____ Card No.: _____ Security Code_____