



New Client Intake Form

Please Complete Highlighted Sections & Return to New Day Staff

Name:	
Date Of Birth:	Primary Language:
Social Security Number:	
Medicaid ID:	
Address:	
City:	Zip code:
Phone:	Text messaging capable? Y or N
Guardian:	Court Appointed? Y or N
E-mail Address:	

Community Center Board:	
Resource Coordinator:	
Living Arrangement:	
Type Of Service Enrollment	
<input type="checkbox"/> DD/COMP	<input type="checkbox"/> CES
<input type="checkbox"/> SLS	<input type="checkbox"/> Private Pay/ Other:
SIS Level:	Date Of Last Adjustment:

Active Diagnosis List	
Developmental Disability	Intellectual Disability
<input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Other <input type="checkbox"/> Epilepsy <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Autism	<input type="checkbox"/> Mild <input type="checkbox"/> Profound <input type="checkbox"/> Moderate <input type="checkbox"/> Unspecified <input type="checkbox"/> Severe
Special Health Care Needs	Assistance With Toileting
<input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Other	<input type="checkbox"/> Full Assistance <input type="checkbox"/> Prompting <input type="checkbox"/> Transfer <input type="checkbox"/> Clean-up/Wiping <input type="checkbox"/> Independent Toileting
Allergies:	
<input type="checkbox"/> Food: <input type="checkbox"/> Drug: <input type="checkbox"/> Environmental: <input type="checkbox"/> Other:	

General Description

Sex:	Hair Color:
Height:	Eye Color:
Weight:	Nation/Tribe/Race/Ethnicity:

Meal Plan

Feeding Protocol?:
Food Texture:
<input type="checkbox"/> Food Eaten at Normal Consistency <input type="checkbox"/> Food Consistency Altered: Chopped <input type="checkbox"/> Food consistency altered: Pureed <input type="checkbox"/> Food consistency altered: Ground <input type="checkbox"/> Food consistency altered: Uses Thickener
Mealtime Status:
<input type="checkbox"/> Eats independently with adaptive equipment: <hr/> <input type="checkbox"/> Eats independently without adaptive equipment <input type="checkbox"/> Requires support to eat <input type="checkbox"/> Requires Physical Assistance <input type="checkbox"/> Requires Physical Prompting <input type="checkbox"/> Requires Verbal Prompting

Behavioral Guidelines

ISSP Goal: <i>What are your hopes and dreams? Education development, interpersonal relationships, employment/ vocational development, recreation and leisure, community living skills, self-advocacy, etc.?</i>