



Realizing life's potential

REHABILITATION SERVICES INTAKE APPLICATION

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|---|--------------------------------------|
| NAME: | SOCIAL SECURITY #: |
| ADDRESS: | ZIP CODE: |
| CITY: | PHONE: |
| BIRTHDATE: | Email: |
| EMERGENCY CONTACT NAME: | EMERGENCY NUMBER: |
| INCOME: __SSI __SSDI __FAMILY __OTHER: _____ | CITIZEN: __YES __NO |
| ARE YOU YOUR OWN GUARDIAN? __YES __NO | GUARDIAN NAME:GUARDIAN PHONE: |

PERSONAL:

| | |
|--|--|
| WHO DO YOU LIVE WITH? (SELECT ALL THAT APPLY) | __ALONE __PARENT __SPOUSE __CHILDREN __FRIEND __RELATIVES |
| STATUS: | __SINGLE __MARRIED __WIDOWED __DIVORCED |
| ARE YOU RESPONSIBLE FOR CARE OF CHILDREN? | __NO __YES, HOW MANY? WHEN? |
| DO YOU OR A FAMILY MEMBER HAVE HEALTH INSURANCE? | __YES __NO __MEDICARE __MEDICAID __OTHER: _____ |
| WHAT DO YOU DO IN YOUR FREE TIME (HOBBIES AND INTERESTS)? | |

LIST MEMBERS OF IMMEDIATE FAMILY:

| NAME | RELATIONSHIP | AGE | OCCUPATION | YEARS OF SCHOOL |
|------|--------------|-----|------------|-----------------|
| | | | | |
| | | | | |

EDUCATION:

| SCHOOL/TRAINING(S) ATTENDED | DATES ATTENDED | DIPLOMA/DEGREE | AREA OF STUDY |
|--------------------------------|----------------|----------------|---------------|
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MILITARY:

| | |
|---------------|--|
| BRANCH | __ARMY __NAVY __AIR FORCE __MARINES |
| DATES: | __OTHER _____ |

HEALTH: (DESCRIBE ANY HEALTH CONCERNS YOU ARE AWARE OF)

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PHYSICAL RESTRICTION(S):

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| DO YOU HAVE ANY PHYSICAL RESTRICTIONS THAT YOUR DOCTOR HAS TOLD YOU ABOUT? | <input type="checkbox"/> LIFTING UP TO: <input type="checkbox"/> 40 <input type="checkbox"/> 30 <input type="checkbox"/> 20 <input type="checkbox"/> 10 POUNDS <input type="checkbox"/> STANDING <input type="checkbox"/> CLIMBING <input type="checkbox"/> BENDING <input type="checkbox"/> REACHING <input type="checkbox"/> WALKING <input type="checkbox"/> PULLING <input type="checkbox"/> SITTING |
|---|--|

MEDICATION(S):

| MEDICATION NAME | DOSE | FREQUENCY |
|-----------------|------|-----------|
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| | | |

HOSPITALIZATIONS (LIST ALL HOSPITALIZATIONS WHERE YOU HAVE HAD TO STAY OVERNIGHT IN PAST 5 YEARS)

| DATES | WHERE | FOR WHAT? |
|-------|-------|-----------|
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| | | |

| DOCTOR NAME | ADDRESS | PHONE |
|-------------|---------|-------|
| | | |

SOCIAL WORKER/PSYCHOLOGIST/THERAPIST:

| DOCTOR OR CLINIC NAME | ADDRESS | PHONE | # OF VISITS PER MONTH |
|-----------------------|---------|-------|-----------------------|
| | | | |
| | | | |

MOBILITY:

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|---|
| <input type="checkbox"/> INDEPENDENT <input type="checkbox"/> PARTIAL <input type="checkbox"/> WHEELCHAIR <input type="checkbox"/> WALKER <input type="checkbox"/> NO MOBILITY |
| HOW DO YOU PLAN TO GET TO PROGRAM DAILY? <input type="checkbox"/> FRIEND <input type="checkbox"/> PARENT <input type="checkbox"/> BUS <input type="checkbox"/> MY CAR, <input type="checkbox"/> BIKE <input type="checkbox"/> JVS |
| DO YOU HAVE A DRIVERS LICENSE OR CAR? <input type="checkbox"/> DRIVER'S LICENSE <input type="checkbox"/> CAR |

ASSISTIVE DEVICES: ("X" ALL THAT YOU USE)

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| <input type="checkbox"/> GLASSES <input type="checkbox"/> CONTACTS <input type="checkbox"/> SPECIAL SHOES <input type="checkbox"/> HEARING AID <input type="checkbox"/> CRUTCHES <input type="checkbox"/> ARTIFICIAL LIMB <input type="checkbox"/> DETURES <input type="checkbox"/> WHEEL CHAIR <input type="checkbox"/> OTHER(S): _____ |
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SUBSTANCE ABUSE:

| | |
|--|---|
| 1) DO YOU CURRENTLY DRINK ALCOHOL? WHAT? | <input type="checkbox"/> YES <input type="checkbox"/> NO HOW OFTEN? |
| 2) DO YOU CURRENTLY USE NON-PERSCRIPTION DRUGS? | <input type="checkbox"/> YES <input type="checkbox"/> NO WHAT? HOW OFTEN? |
| 3) HAVE YOU DRANK OR TAKEN NON-PERSCRIPTION DRUGS IN THE PAST? | <input type="checkbox"/> YES <input type="checkbox"/> NO WHEN? |
| 4) HAVE YOU EVER RECEIVED TREATMENT FOR SUBSTANCE ABUSE? | <input type="checkbox"/> YES <input type="checkbox"/> NO WHEN? |

LEGAL BACKGROUND:

| | |
|--|---|
| 1) HAVE YOU EVER BEEN CONVICTED OF DRIVING UNDER THE INFLUENCE, IMPAIRED OR DRUNK DRIVING? | <input type="checkbox"/> YES <input type="checkbox"/> NO WHEN: |
|--|---|

| | |
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| 2) CONVICTED OF ANY NON-TRAFFIC VIOLATION, REC'D PROBATION OR BEEN TO JAIL/PRISON? FOR WHAT: | <input type="checkbox"/> YES <input type="checkbox"/> NO WHEN: |
| 3) ARE YOU ON PAROLE OR PROBATION? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4) PAROLE OR PROBATION OFFICERS? | NAME: NUMBER: |
| 5) CURRENT LEGAL ACTION PENDING? (EXPLAIN) | <input type="checkbox"/> LAWSUIT <input type="checkbox"/> CLAIMS <input type="checkbox"/> WARRANTS <input type="checkbox"/> WORKER'S COMPENSATION <input type="checkbox"/> COURT CASE <input type="checkbox"/> CHILD SUPPORT <input type="checkbox"/> ARRESTS <input type="checkbox"/> OTHER |
| 6) HAVE YOU EVER FILED FOR WORKER'S COMPENSATION? IF SO, WHAT COMPANY AND WHEN? | WHEN: _____ WHAT COMPANY: |

WORK HISTORY

| DATES | COMPANY NAME OR D | JOB OR DUTIES |
|-------|-------------------|---------------|
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VOCATIONAL GOALS:

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| 1) DO YOU WANT A JOB? | <input type="checkbox"/> YES <input type="checkbox"/> NO WHY? |
| 2) WHAT JOB DO YOU WANT 5 YEARS FROM NOW? (LONG-TERM JOB GOAL) | |
| 3) WHAT JOBS ARE YOU CURRENTLY INTERESTED IN? (SHORT-TERM GOAL) | |
| 4) WHAT TYPES OF JOBS DO YOU KNOW YOU DO NOT WANT TO DO? | |
| 5) IS THERE ANYTHING THAT MAY MAKE IT DIFFICULT FOR YOU TO DO A JOB? | |
| 6) LIST ANY INFORMATION YOU FEEL WE SHOULD KNOW ABOUT TO ASSIST YOU IN ATTAINING YOUR GOALS. | |

PARTICIPANT'S SIGNATURE

DATE

WITNESS'S SIGNATURE

DATE