Day Services Intake *(supplements Initial Intake form)*

Client Name: ____ **DOB:** ______________________

Today's Date: __________________ **Person Completing Form:** ______________________________________

Personal Values:

____
____
____
____

Likes/Preferences:

____
____
____
____
____
____

Dislikes/Concerns:

____
____
____
____
____
____

Transportation Needs (i.e., who will be responsible to and from day program, specific needs):

____
____
____

Diet and Nutrition (include level of independence, specific needs for meals):

____
____
____
____
____
____

Hygiene/Toileting (include level of independence/support needs):

____
____
____
____

High Risk Needs (seizure, dining, fall, etc…):

____
____
____
____
____
____

Need for Supportive Devices (i.e., glasses, brace, walker, hearing aide):

____
____
____
____
____
____

Skill Ability *(initial ISP goals will be developed using this information)*:

Skill Area	**Ability**		**Skill Area**	**Ability**
Identify letters			Communication-mand/tact	
Read site words			Social Communication-initiate	
Reading with comprehension			Social Communication-response	
Identify numbers			Personal Boundaries	
Add			Household Tasks	
Subtract			Job Skills	
Identify Money			Community Safety	
Money Management			Personal Hygiene	
Writing			Attending to Task	

Additional Information-Skill Ability: ____
____
____
____

Additional Information:

Day Services Employee/Date