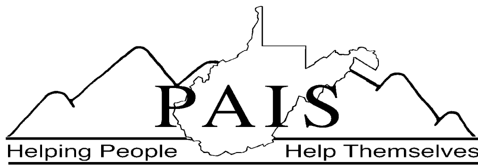

CLIENT AND INTAKE INFORMATION

11/01/2013

DATE:

IDENTIFYING INFORMATION

Name:

DOB:

SS#

Primary Insurance- Type/#

Secondary Insurance- Type/#

Other Insurance- Type/#

Address

Phone

Admission Date

CLIENT AND FAMILY INPUT SURVEY

PREFERRED OUTCOMES FROM PAIS SERVICE COORDINATION SERVICES (What kind of information or support would you like from PAIS?):

WHAT ARE YOUR IMMEDIATE CONCERNS?

WHAT SUPPORTS OR ASSISTANCE DO YOU CURRENTLY RECEIVE?

I WANT MY SERVICE COORDINATOR TO:

I DO NOT WANT MY SERVICE COORDINATOR TO:

LEGAL INFORMATION

Legal Representative: Yes* [ ] No [ ]
If "Yes" Full [ ] Limited [ ]

Name:
Address:
Phone:

Health Care Surrogate: Yes* [ ] No [ ]

Name:
Address:
Phone:

Medical Power of Attorney: Yes* [ ] No [ ]

Name:
Address:
Phone:

Payee: Yes [ ] No [ ]

Name:
Address:
Phone:

Conservator: Yes [ ] No [ ]

Name:
Address:
Phone:

Advocate: Yes [ ] No [ ]

Name:

Address:

Phone:

Emergency Contact Information:

***Services cannot be rendered unless documentation has been provided.**

SOCIAL INFORMATION

Who can I count on?

Who is a good friend?

What people, organizations, or networks am I involved with?

Who are the people paid to be in my life (i.e. staff)?

Who would I like to participate in developing my plan?

What are my short-term and long-term goals and dreams? My dreams should be positive and possible. *(Where do I want to live? Ideal job? Who do I want to live with? Dream vacation? What do I want to learn?)* Who is going to help me achieve these goals/dreams?

What do I expect to be different as a result of receiving services and supports? What outcomes do I expect to accomplish with the help of supports?

What are the things that I like and dislike? What things do I consider pleasant and important? What do I like to do during my leisure time? What community activities do I enjoy?

What are my strengths? What am I good at?

MEDICAL INFORMATION

Who are my current doctors and what service do they provide? When was I last seen by each doctor? What was the outcome of those visits?

What medications am I currently receiving? Dosage? Frequency? What do my medications treat?

What is my medical history? Specify significant events.

What are my specific health and safety concerns (special diet, ambulation issues, sleep problems, bowel/bladder, speech, allergies, adaptive equipment, etc.)?

RECOMMENDATIONS FOR FURTHER EVALUATION OF CLIENT'S PHYSICAL, EMOTIONAL, AND/OR BEHAVIORAL NEEDS, SOCIAL STRENGTHS, AND PREFERENCES:

Relationship	Signature and Credentials	Date
Client		
Legal Representative		
Service Coordinator		