

Absolute Ability Support Services ABN 95 323 349 616

Client Intake Form

Absolute Ability Support Services appreciates that everyone is unique, please help us to get to know you by answering the following:

Client Details	
Client First Name:	
Client Last Name:	
Client Date of Birth:	
NDIS Number:	
NDIS Funding Type:	<input type="checkbox"/> Agency Managed (NDIS) <input type="checkbox"/> Self Managed <input type="checkbox"/> Plan Managed
Provide Plan Manager (if applicable) see NDIS Funding Type	
Address	
Contact Number	
Email	
Preferred method of contact	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> SMS

Representative or Emergency Contact Details	
First Name	
Last Name	
Relationship to Client	
Address	
Phone Number	
Email	
Preferred method of contact	<input type="checkbox"/> Phone <input type="checkbox"/> Email

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	<input type="checkbox"/> Mail <input type="checkbox"/> SMS
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About you	
Living Situation	<input type="checkbox"/> Own home (alone) <input type="checkbox"/> Own Home (with family) <input type="checkbox"/> Supported Accommodation <input type="checkbox"/> Temporary <input type="checkbox"/> Other: _____
Aboriginal or Torres Strait Islander descent?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the Client have a current Behavioural Support Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Formal Diagnosis	
Secondary Formal Diagnosis	
Do you have any allergies? If yes please provide below	
Please provide all medical diagnoses and medicine that may affect the support provided	
Please provide the name and contact number for Client's Doctor	

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<p>Please disclose any legal issues that may affect service eg. Apprehended Violence Order</p>	
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Communication	
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Type	<input type="checkbox"/> Verbal <input type="checkbox"/> Non-Verbal <input type="checkbox"/> Communication aids required <input type="checkbox"/> Other: _____
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Are you of a culturally or linguistically diverse background?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
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Do you have any culture, diversity, values and beliefs of which we should be aware?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
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Languages Spoken	<input type="checkbox"/> English <input type="checkbox"/> Other: _____
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Is an Interpreter required?	<input type="checkbox"/> No <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Language
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Consent	
Do you consent to participating in and use of...	<input type="checkbox"/> Photos for Goal Data <input type="checkbox"/> Photos for Social Media <input type="checkbox"/> Photos for the website <input type="checkbox"/> Participating in audits in respect of our business by the NDIS Commission and its auditors <input type="checkbox"/> Your personal information being recorded in audio and/or visual format <input type="checkbox"/> None of the above

Dietary Requirements		
I have the following allergies/intolerances and my favourite food is...		
No dietary requirements	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vegetarian	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vegan	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I am allergic to (please list)		
I am unable to eat (sensory/intolerances)		
My favourite food is...		
Absolute Ability Support Services can assist me during mealtimes by...		
<input type="checkbox"/>	I can identify what foods are safe for me to eat (if required due to allergy or dietary requirements).	
<input type="checkbox"/>	If I have a food allergy, I have provided Absolute Ability Support Services with a management	

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	plan.
<input type="checkbox"/>	If required I will bring any medications to assist me with my allergy and have completed the relevant medical forms
<input type="checkbox"/>	I prefer to provide my own food and will do so

Mental Health			
I have/experience...			
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Psychosis	<input type="checkbox"/>	Schizophrenia
<input type="checkbox"/>	Bipolar	<input type="checkbox"/>	Other
I would like Absolute Ability Support Services to help me manage this by...			
My triggers may include...			
I am supported/linked with the following organisations who assist me... (Please supply relevant management plans.)			
<input type="checkbox"/>	I have received medical support to assist me and Absolute Ability Support Services has a copy of any relevant management plans to help me manage.		

Physical Health			
I have...			
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Sleep Apnoea
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Dietary Needs
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Blood Disorders
<input type="checkbox"/>	Visual Impairment	<input type="checkbox"/>	Hearing Impairment

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<input type="checkbox"/>	Cognitive Impairment	<input type="checkbox"/>	Heart Conditions
<input type="checkbox"/>	Allergies to:		
<input type="checkbox"/>	Other:		
I am on the following medications:		List of medications:	
I would like Absolute Ability Support Services to help me manage this by...			
Please supply Absolute Ability Support Services with relevant management plans prior to commencing programs.			

Practical Support Needs			
Check the boxes which best represent you and your support needs...			
Behaviour	I can do independently	I need a little help	I cannot do independently
Traffic awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying with the group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating appropriately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking after property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being aware of personal space	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeping my hands to myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travelling safely in a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Following instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Swimming and safety around water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can handle my own spending money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am comfortable in my sleeping routine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Absolute Ability Support Services can assist me by...			
<input type="checkbox"/>	I have provided Absolute Ability Support Services with any relevant behaviour plans for assisting me when required.		

A bit about you and your goals		
To help us understand you better, please fill the below:		
	My strengths are (what I am good at)...	
	I like...	
	I don't like... (please include any sensory considerations)	
	You will know when I am happy by...	
	You will know when I am unhappy by...	
	I prefer to communicate by...	
	What are your goals for the next 12 months?	
	How have these goals changed since your previous Support Plan (if applicable)	

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	<p>How do your existing support from us or other providers help achieve desired outcomes? Is there any opportunity to use less intrusive options, in accordance with contemporary evidence-informed practices that meet participant needs and help achieve desired outcomes.</p>	
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Health requirements

Activity	Tick one		Outline condition, treatments, aids/assistance required, from whom and when
Continence	<input type="checkbox"/>	Continent with regular bowel and bladder action	
	<input type="checkbox"/>	Constipation, diarrhoea or incontinence (using medication, supplements, pads)	
	<input type="checkbox"/>	Medical interventions (catheter, stoma bag)	
Skin Integrity	<input type="checkbox"/>	No skin problems	
	<input type="checkbox"/>	Some skin problems (rash, skin treatments)	
	<input type="checkbox"/>	Pressure areas (currently have, at risk, or had in past)	
Swallowing	<input type="checkbox"/>	No swallowing issues	
	<input type="checkbox"/>	Some swallowing problems (choking, coughing during normal meal, reduced appetite)	
	<input type="checkbox"/>	Major swallowing difficulties (modified diet, feeding tube)	

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Health professionals	<input type="checkbox"/>	Have had a GP check up in the last 12 months	
	<input type="checkbox"/>	See a specialist regularly	
	<input type="checkbox"/>	Have a case manager/support coordinator	
Muscular pain	<input type="checkbox"/>	No pain	
	<input type="checkbox"/>	Moderate pain	
	<input type="checkbox"/>	Severe pain	
Nerve pain	<input type="checkbox"/>	No pain	
	<input type="checkbox"/>	Moderate pain	
	<input type="checkbox"/>	Severe pain	
Falls	<input type="checkbox"/>	No falls in past 12 months	
	<input type="checkbox"/>	Less than 3 falls and no serious injury from a fall in past 12 months	
	<input type="checkbox"/>	More than 3 falls or a serious injury from a fall in the past year	
Muscular issues (other than pain)	<input type="checkbox"/>	No problems	
	<input type="checkbox"/>	Some muscle weakness, tremor, spasms, spasticity or problems with balance	
	<input type="checkbox"/>	Serious muscle weakness, tremor, spasticity or problems with balance	
Other health concerns	<input type="checkbox"/>	Fatigue	
	<input type="checkbox"/>	Visual disturbance	
	<input type="checkbox"/>	Temperature intolerance	
	<input type="checkbox"/>	Other comorbidities	

Social Requirements

Activities	Outline how you want to do this activity	Provide details of the activity, the time spent, the assistance required, from whom and when (including vouchers)
Example: I love cooking	<ul style="list-style-type: none"> • I like to watch cooking shows on TV • I like to buy good cook books • I like to prepare my own meals • I like to attend cooking classes regularly 	<ul style="list-style-type: none"> • I need a TV in my room with good reception. • I need a computer/tablet and high speed internet or Wi-Fi to buy books online. • I would like to have access to a kitchen to prepare my own meals 2 x per week • I need a maxi taxi and carer/staff member to take me to cooking classes once a month
Family:		
Hobbies & Interests:		
Religion & spirituality		
Outings: E.g. theatre, cafes, exhibitions, drives, group activities		
Computer: E.g. games, shopping, education, bookings		
Employment: Education, Volunteering		
Sports:		
Music: Likes, dislikes		
Movies/TV: Likes, dislikes		
Well-being: E.g. exercise, gym, swimming, massage, yoga,		

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meditation etc...		
Food and alcohol: Likes, dislikes, diets		
Sex and intimacy		
Other:		

Behavioural requirements

Issue	Tick one	Assistance I need	Outline the issue, aids, assistance and management strategies required
Communication	<input type="checkbox"/>	No assistance required (including independent use of aids and adaptive technology)	
	<input type="checkbox"/>	Some assistance required (prompting, assistance with aids)	
	<input type="checkbox"/>	Assistance always required	
Memory problems Confusion	<input type="checkbox"/>	No	
	<input type="checkbox"/>	Yes	
Concentration problems	<input type="checkbox"/>	No	
	<input type="checkbox"/>	Yes	
Planning problems	<input type="checkbox"/>	No	
	<input type="checkbox"/>	Yes	
Spiritual needs	<input type="checkbox"/>	No	
	<input type="checkbox"/>	Yes	

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Mood	<input type="checkbox"/>	Mostly positive	
	<input type="checkbox"/>	Experience sadness, anxiety or emptiness around 50% of time	
	<input type="checkbox"/>	Feelings of anxiety, sadness or emptiness lasting most of the day, nearly every day	
Decision Making	<input type="checkbox"/>	No help needed	
	<input type="checkbox"/>	Need some help	
	<input type="checkbox"/>	Not able to make any decisions	
Do you have a will?	<input type="checkbox"/>	No	
	<input type="checkbox"/>	Yes	
Do you have an Enduring Power of Attorney or Guardian?	<input type="checkbox"/>	No	
	<input type="checkbox"/>	Yes	
Do you have an Advanced Care Plan?	<input type="checkbox"/>	No	
	<input type="checkbox"/>	Yes	

What things are important for people to understand about you when caring for you?	Provide details	Outline how you like this to be managed
Who makes the decisions?		
What routines do you have?		
What makes you happy?		
What helps you relax?		
What causes you stress?		
What makes you frustrated?		

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What makes you angry?		
Other		

Matching

We recognise the significance of matching the right staff member to meet your needs and consider a number of factors such as personality, language, culture and skill requirements. We encourage and support you to be involved in the process of matching your needs with the right staff. We can also support you to access an advocate of your choice to support you in this process.

Based on the above, what characteristics would you like to see in any staff member supporting you?	Provide details	Notes in relation to potential Workers discussed with client who could provide supports (given preferences below and relevant training of Workers to deliver such supports)
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No preference	
Personality type		
Languages spoken		
Culture or religion		
Specific needs, skills and knowledge required		
Do you require any intrusive support?		
Do you have any specific needs which require monitoring and/or daily support, which Workers are appropriately trained to understand the Client's needs and preferences.		
What specific training may be required to provide support and services to you?		

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Consent

Please sign below to indicate your consent and agreement to the details set out in this client intake form above

If no, please specify

Signed for and on behalf
of **Ashlee Sarah Annette Bazley**
ABN 95 323 349 616 (Absolute Ability Support Services), by:

..... Date:/...../.....
Signature

.....
Name (please print)

Signed by the **Client**:

..... Date:/...../.....
Signature

.....
Name (please print)

Signed by the **Representative**:

..... Date:/...../.....
Signature

.....
Name (please print)

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