



Date: \_\_\_\_\_

Name of individual filling out this form: \_\_\_\_\_

**Participant Information**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ years Height: \_\_\_\_\_ feet \_\_\_\_\_ inches Weight: \_\_\_\_\_ pounds

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Best phone number for medical and/or transportation concerns: \_\_\_\_\_

Gender:  Female  Male Legal Guardian: \_\_\_\_\_

Living Arrangement: \_\_\_\_\_

Disability/Diagnosis: \_\_\_\_\_

Date of Diagnosis/Injury: \_\_\_\_\_ month \_\_\_\_\_ year

Ethnicity: Asian American, Hispanic, Native American, Caucasian, Other \_\_\_\_\_

**Registration/Scheduling Contact**

Name: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Transportation to Tavon Learning Center**

Parent/caregiver \_\_\_\_\_ Access \_\_\_\_\_

Who is authorized to pick up participant?

\_\_\_\_\_



**Medical Emergency Information**

Hospital of Choice \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_

\_\_\_\_\_

**Experience**

Have you ever participated in a similar program?  Yes  No Where?

\_\_\_\_\_

What type of work are you currently doing or have you done in the past?

\_\_\_\_\_

What type of volunteering are you currently doing or have you done in the past?

\_\_\_\_\_

\_\_\_\_\_

**Communication**

Please check all that apply and provide details.

Completely Verbal:

\_\_\_\_\_

Limited Verbal:

\_\_\_\_\_

Understands 2-step directions:

\_\_\_\_\_

Understands spoken words:

\_\_\_\_\_

Reading

Ability: \_\_\_\_\_



Sign Language:

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Gestures:

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Pictures:

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Communication Device:

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Other:

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Describe any communication suggestions or modifications to be aware of:

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### **Mobility**

Do you have a mobility challenge?  Yes  No

If yes, please check all that apply:

- Balance  Dexterity  Use crutches
- Coordination  Visual Impairment  Use Manual Wheelchair
- Endurance/Fatigue  Spinal Cord Injury  Use Power Wheelchair
- Hemiplegia  Use Cane  Use Walker

Other:

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Wheelchair users only:

How often do you use your chair?

- Always  Only when fatigued  Only when outside  Only away from home

Do you operate the wheelchair independently?  Yes  No

Do you need assistance with transfers?  Yes  No (If yes, please select from the following)

- Minimal Assist  Moderate Assist  Always

Weight shifts?  Yes  No How often? \_\_\_\_\_ Assistance/Props: \_\_\_\_\_

Please share any other mobility concerns:

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Toileting:  Independent  Partial Assist  Total Assist

Bladder needs:  Incontinent  Needs reminders  Needs to go very often

Toileting Schedule:

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Other:

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### **Dietary/Eating**

Dietary Needs:

None  Vegetarian  Diabetic  Gluten/Casein Free

Thick Liquids  Tube

Other Restrictions (such as fluid):

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History of Choking?  Yes  No If yes, please explain:

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Food Allergies?  Yes  No If yes, please list:

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Do you need assistance with eating?  None  Partial Assist  Total Assist

Please explain:

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What do you use at home? (special bibs, cups, utensils, plates): \_\_\_\_\_

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### **Health**

Do you have any health concerns you would like us to know about?  Yes  No

If yes, please explain:

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Please list any medications that you are currently taking, including over-the-counter medications:

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Please list all allergies, including food or medications:

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Do you have a seizure disorder?  Yes  No

If yes, what is the specific type of seizure?

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How frequently do you have seizures?

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What is the current status of your seizure disorder?  Active  Controlled Describe your seizure. Do you have any warning? What is the after effect of the seizure?

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Describe specific care required in the event of a seizure and recovery time:

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### **Interests**

Please check any boxes that apply and use the additional space to provide details on specific likes and dislikes:

Gardening: \_\_\_\_\_

Outdoors: \_\_\_\_\_

Animals: \_\_\_\_\_

Cooking: \_\_\_\_\_

Exercise: \_\_\_\_\_

Sports: \_\_\_\_\_

Swimming: \_\_\_\_\_

Yoga: \_\_\_\_\_

Art: \_\_\_\_\_

Community Outings: \_\_\_\_\_

Movies: \_\_\_\_\_



- Music: \_\_\_\_\_
  - Instrument(s): \_\_\_\_\_
  - Singing: \_\_\_\_\_
  - Reading: \_\_\_\_\_
  - Independent Living: \_\_\_\_\_
  - Other: \_\_\_\_\_
- 

### **Behavior**

What challenging behaviors do you have (check all that apply and describe what the behaviors look like – the more detail, the better):

- Tantrums (*example of behavior, such as: high pitched voice, crying*):  
\_\_\_\_\_
- Physical aggression (*example of behavior, such as: strikes, bites, tears clothes of others*): \_\_\_\_\_
- Verbal aggression (*example of behavior, such as: yelling or swearing at others*):  
\_\_\_\_\_
- Property destruction (*example: attempting or breaking furniture, putting holes in walls*): \_\_\_\_\_
- Elopement (*example of behavior, such as: running away from buildings*):  
\_\_\_\_\_
- Self-Injurious behavior (*example of behavior, such as: pinching, biting or hitting self*):  
\_\_\_\_\_
- Other behavior(s) not listed above:  
\_\_\_\_\_  
\_\_\_\_\_

What are some things or situations that could trigger a behavior?

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What are the underlying reasons why the challenging behavior(s) occur (for example: to escape/avoid, attention seeking, seeking access to material, sensory stimulation, etc)?

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If a behavior happens, what can we do to help?

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What can you do to cope when you are triggered?

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Fill out the following on how to work best with you:

DO:

DO NOT:




What are your current goals?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What would you hope to see as an outcome from attending Tavon Learning Center?

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**Please call the Tavon Learning Center with any questions: 425-999-2269**

**Email this form to: [contactus@tavoncenter.org](mailto:contactus@tavoncenter.org) or**

**mail to: Tavon Learning Center  
PO Box 1243  
Issaquah, WA 98027**

*Please attach any additional applicable paperwork (i.e. ISP, IEP, care plans, etc.) with the submission of your intake form.*