Date: _____

Name of individual filling out this form: _____

$50 Application Fee included? Yes_____

Participant Information

Name: _____ Birth Date:_____

Address:_____

City: _____State: _____Zip: _____

Age: _____years Height: _____ 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?

_____

TAVON

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 or 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:

_____

□ Gestures:

_____

□ Pictures:

_____

□ Communication Device:

_____

□ Other:

_____

Describe any communication suggestions or modifications to be aware of:

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:

_____

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:

Toileting

Toileting: □ Independent □ Partial Assist □ Total Assist

Bladder needs: □ Incontinent □ Needs reminders □ Needs to go very often

Toileting Schedule:

_____

Other:

_____

TAVON

Dietary/Eating

Dietary Needs:

□ None □ Vegetarian □ Diabetic □ Gluten Free ___Casein Free ___

□ Thick Liquids □ Tube

□ Other Restrictions (such as fluid):

_____

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

_____

Food Allergies? □ Yes □ No If yes, please list:

_____

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

Please explain:

_____

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

Health

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

If yes, please explain:

_____

_____

_____

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

_____

Please list all allergies, including food or medications:

_____

Chronic or existing medical conditions (asthma, seizures, diabetes, etc.)

_____

_____

_____

Do you have a seizure disorder? □ Yes □ No

If yes, what is the specific type of seizure?

_____

How frequently do you have seizures?

_____

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?

_____

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

_____

_____

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?

_____
_____
_____
_____

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)?

_____
_____
_____
_____

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

_____
_____

TAVON

_____
_____

What can you do to cope when you are triggered?

_____
_____
_____

Does the participant have an IEP or Behavior Plan? YES___ NO____
If yes, please include it with this application.

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

DO:	DO NOT:

Goals

What are your current goals?

1. _____
2. _____
3. _____

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

_____
_____
_____

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

Email this form to: holly@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.