

# Highlands Haven Family In-Take Form

Contact: Jenny Golden

Email: [jenny@churchofthehighlands.com](mailto:jenny@churchofthehighlands.com)

Phone: 205-439-4331

Name of Applicant: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F

Father's Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

If Caretaker, relationship to Applicant: \_\_\_\_\_ Language Spoken at home: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_-\_\_\_\_-\_\_\_\_ Work (father): \_\_\_\_-\_\_\_\_-\_\_\_\_ Work (mother): \_\_\_\_-\_\_\_\_-\_\_\_\_

Emergency contacts (2 people familiar with habits and conditions)

Name \_\_\_\_\_ Phone \_\_\_\_-\_\_\_\_-\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_-\_\_\_\_-\_\_\_\_ Relationship \_\_\_\_\_

Siblings' (under 16) names and ages: \_\_\_\_\_

Pets: \_\_\_\_\_

Check this box if we CANNOT share this information with other ministries at Church of the Highlands.

## MEDICAL AND FUNCTIONAL HISTORY

Applicant's Primary Disability: \_\_\_\_\_

Current medications:  None Type: \_\_\_\_\_

Medication Side Effects: \_\_\_\_\_

Medication allergies:  No  Yes  Penicillin  Aspirin Other: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs

Vision:  Glasses  Contacts Vision corrected with these aids:  Yes  No

Seizures:  None  Controlled  Uncontrolled Frequency: \_\_\_\_\_

If seizures occur, please describe: \_\_\_\_\_

Respiratory problems:  None  Bronchitis  Pneumonia  Asthma Other: \_\_\_\_\_

Heart problems:  No  Yes Type: \_\_\_\_\_

Need one-on-one assistance:  No  Yes Any other medical concern: \_\_\_\_\_

## Speech and Cognition

The applicant communicates in the following ways:

Non-verbal but vocalizes  Says words  Talks in sentences but may be hard to understand

Talks in sentences and is easy to understand.  Uses a communication board

Uses a computer-assisted device Other: \_\_\_\_\_

Hearing problems:  None  Uses a hearing aid  Uses sign language

Following directions:

Is unable to follow directions  Follows simple one-step directions  Follows two-step directions

Has no difficulty following directions Other: \_\_\_\_\_

Does the applicant read?  Yes  No What level? \_\_\_\_\_

Does the applicant write?  Yes  No What level? \_\_\_\_\_

Applicant's most recent school placement: \_\_\_\_\_

Applicant's place of employment or volunteer work (if applicable): \_\_\_\_\_

**Mobility**

- Walks independently     Uses a wheelchair     Uses braces or orthotics    *Type of orthotic:* \_\_\_\_\_
- Uses a different assistive device    *Type of device:* \_\_\_\_\_
- Falls on occasion    *Under what circumstances:* \_\_\_\_\_

List any special positioning needs or mobility issues: \_\_\_\_\_

**Nutrition**

Food Allergies:  No  Yes *Type:* \_\_\_\_\_

Special Food Issues:  Liquid diet     Soft diet

Difficulty swallowing:  No  Yes  Food needs to be cut up     Tendency to choke

Other dietary restrictions: \_\_\_\_\_

Food preferences: \_\_\_\_\_

**Activities of Daily Living**

Toileting:  Independent  Wears diaper/pull-ups  
 Bedwetting     Requires assistance    *Type:* \_\_\_\_\_

Eating:  Feeds self     Requires assistance    *Type:* \_\_\_\_\_

Dressing:  Independent  Requires assistance    *Type:* \_\_\_\_\_

Bathing:  Independent  Requires assistance    *Type:* \_\_\_\_\_

**Social/Behavioral Issues**

- Behavioral Tendencies:  Temper tantrums     Running away     Yelling     Biting
- Hitting     Refuses to follow directions     Pushing     Aversion to touch

*Other:* \_\_\_\_\_

How do you handle this/these behaviors? \_\_\_\_\_

What things or activities does the applicant like? \_\_\_\_\_

What things or activities does the applicant dislike? \_\_\_\_\_

Any special fears? \_\_\_\_\_

Any hobbies or talents? \_\_\_\_\_

We should contact you if: \_\_\_\_\_

Please provide any other information you feel is pertinent: \_\_\_\_\_

Church Home:  Church of the Highlands     Other church name:  No Church Home

Person completing this form: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

Please sign below giving your consent for emergency medical treatment if we are unable to contact you.

Parent/Caregiver Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*(Typed name will suffice)*