Daniel's Place Personal Care Packet

Name _____ Social Security # _____

Address _____ Birthdate _____/_____/_____ Sex _____

City _____ State _____ Zip _____

Parent(s)/Guardian _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Email Address _____

School / Vocational Program _____ Phone # _____

Doctor's Name _____ Phone # _____

Dentist's Name _____ Phone # _____

Preferred Hospital _____

Two Emergency Contacts if parent(s) / guardian are not available:

Name _____ Name _____

Address _____ Address _____

_____ _____

Phone # _____ Phone # _____

Relationship _____ Relationship _____

AUTHORIZATION AND PERMISSION FOR ACTIVITIES

I, _____, give Daniel's Place Staff permission to allow
(parent, guardian, person responsible)

_____ to participate in the following activities:
(name of guest)

YES	NO	ACTIVITY
☐	☐	Swimming (required one-to-one supervision for all swimming)
☐	☐	Park or playground
☐	☐	Car rides
☐	☐	Shopping
☐	☐	Community Integration Activities
☐	☐	Walks (with wagon, stroller, or wheelchair, if needed)
☐	☐	Restaurant (i.e. McDonald's, Dairy Queen, etc.)
☐	☐	Church or Concert

Date _____ Signature _____

Allergies _____

Type of Disability / Diagnosis _____

Brief description of condition _____

_____

_____

_____

_____

Check those items that will help us understand the disability.

	YES	NO	PARTIAL	COMMENT
Physically Impaired	☐	☐	☐	_____
Visually Impaired	☐	☐	☐	_____
Hearing Impaired	☐	☐	☐	_____
Verbally Impaired	☐	☐	☐	_____
Emotionally Challenged	☐	☐	☐	_____
Behaviorally Challenged	☐	☐	☐	_____
Intellectually Impaired	☐	☐	☐	_____

ROUTINE TIMES

Awakes @ _____

Breakfast @ _____

Lunch @ _____

Dinner @ _____

Bedtime @ _____

_____

_____

_____

_____

_____

MISCELLANEOUS TIMES

Naps @ _____

Bathes @ _____

Snacks @ _____

Favorite TV Program @ _____

_____

_____

_____

_____

_____

_____

SLEEPING

Recommended Bed: ☐ regular bed ☐ hospital bed ☐ crib bed ☐ Rails on bed: ☐ Yes ☐ No

Sleeps in a certain position? ☐ Yes ☐ No Explain _____

_____

Naps? ☐ Yes ☐ No Usual time(s) _____ Length of nap _____ Place of nap _____

Comments _____

Usual bedtime hour _____ Check all that apply: ☐ Nite light on ☐ Light off ☐ Door open ☐ Door closed

☐ No music ☐ Radio/CD; Type of music _____ Favorite toy or blanket _____

Type of activities that would be of interest:

☐ Toys with lights and sounds ☐ Building blocks ☐ Listening to music ☐ Reading books ☐ Singing

☐ Coloring / pencil & paper ☐ Crafts ☐ Computer or TV video games ☐ Table games ☐ Puzzles ☐ Dolls

☐ Trucks / Cars ☐ Train TV/ DVD or video ☐ Card games ☐ Cooking ☐ Walks ☐ Balls ☐ Bike rides

Favorite toys / games _____

_____

Favorite TV shows & times _____

_____

Favorite DVD's / Videos _____

_____

Favorite outdoor activities _____

_____

List any adaptive equipment (i.e. crutches, walker, helmet, wheelchair)

_____

_____

_____

_____

How is the equipment used?

_____

_____

_____

_____

Over the counter medication in case of: Dosage:

Cold _____ _____

Cough _____ _____

Fever _____ _____

Headache _____ _____

Upset stomach _____ _____

Diarrhea _____ _____

Constipation _____ _____

Does the person have menstrual periods? _____ If yes, describe any specific problems _____

_____

Special instructions for giving medications _____

_____

Verbal ☐ Limited Verbalization ☐ Non Verbal ☐

Level of understanding Total ☐ Moderate ☐ Limited ☐ Unknown ☐

Special aides in communication (i.e. sign language, hearing aides, speel board, pictures, writing, etc.)

_____

_____

_____

If a person has no speech, describe how wants are made known: _____

_____

_____

_____

Suggestions for staff to make their wishes known to him/her: _____

_____

_____

MOBILITY

☐ Does not walk ☐ Crawls ☐ Rolls ☐ Walks independently ☐ Walks with walker

☐ Walks with assistance: Explain type of assistance _____

_____

☐ Independently mobile in manual wheelchair ☐ Independently mobile in power wheelchair

☐ Mobile in wheelchair with assistance. Comments _____

_____

☐ Independently transfers ☐ Single person transfer ☐ Two person transfer ☐ Hoyer Lift

Explain transfer assistance _____

_____

Food Allergies _____

☐ Right handed ☐ Left handed ☐ Regular utensils ☐ Non breakable plastic ☐ Special supplied by guest

☐ Regular plate ☐ Plate with edge ☐ Scooper plate ☐ Sectioned plate

☐ Sits on regular chair at table ☐ Need chair with arms at the table ☐ Sits in wheelchair Tray? ☐ Yes ☐ No

Special positioning for eating ☐ Yes ☐ No Describe position _____

_____

_____

_____

Usual amount of time spent eating a meal? _____

DRINKING ☐ Independent ☐ Total assistance ☐ Some assistance ☐ No liquids by mouth

At risk for dehydration? ☐ Yes ☐ No If yes, intervention method _____

_____

Type of cup for drinking? _____ Can use straw? ☐ Yes ☐ No

Usual amount given _____ Frequency _____

Consistency of beverage ☐ Normal (thin) Thicken to: ☐ Syrup ☐ Nectar ☐ Pudding consistency

EATING ☐ Independent ☐ Total assistance ☐ Finger Feeds ☐ Some assistance ☐ No food by mouth

Chewing and swallowing difficulty ☐ Yes ☐ No ☐ Tongue thrust ☐ Bite reflex ☐ Closure problem ☐ G-tube

At risk of Choking / Aspiration? ☐ Yes ☐ No If yes, intervention methods _____

_____

_____

History of seizures ☐ Yes ☐ No If yes, complete the following seizure health care plan.

Medication	Dose	Any side effects

Activity Restrictions ☐ Yes ☐ No If yes, please list _____

Experiences warning signs before seizures ☐ Yes ☐ No ☐ Uncertain

List possible warning signs or behaviors _____

Usual length of seizure _____ Frequency of seizures _____

Describe - What does his/her seizure generally look like when it happens? _____

Specific instructions to follow during the seizure: _____

Describe - General reaction after a seizure: _____

Ever hospitalized for a seizure? ☐ Yes ☐ No If yes, explain _____

TOILETING ☐ Independent ☐ Total assistance ☐ Some assistance ☐ Incontinent (wears diapers/attends)

Can he/she use standard toilet fixtures? ☐ Yes ☐ No Comment _____

Can he/she clean themselves after toileting? ☐ Yes ☐ No Comment _____

Toilet or check diaper / attends: every _____ hours on schedule _____ as requested by the individual

How often does he/she have a BM? _____ Is constipation a risk? ☐ Yes ☐ No

Constipation Intervention Plan _____

Describe the person's usual emotional state_____

_____

Does he/she like to be cuddled and/or hugged? _____

Has he/she been cared for by someone other than family? _____

How does he/she react to strangers? _____

Does he/she enjoy socializing with others? _____

Are there certain things that frighten the person? _____

How much supervision is required? _____

Is this person a flight risk? ____ Yes ____ No If yes, please explain _____

_____

Flight intervention plan ____ Lock all doors ____ Door alarm on ____ Locked gates on playground ____ Close supervision ____ Other _____

_____

Describe any behavior problems (i.e. hitting, screaming, refusing to follow directions, etc.) _____

_____

Describe any obsessive/compulsive behaviors _____

_____

Describe situations which might cause distress and behavior problems _____

_____

What methods work best in controlling unwanted behavior? _____

_____

What rewards do you use for good behavior? _____

_____