INTAKE QUESTIONNAIRE

Harmony Place Support Services strives to assist individuals with their various personal goals, and increase their community opportunities and therefore it is imperative that you help as much as possible with the completion of this form.

Please forward a copy of the completed questionnaire to Jackie Kelly, Program Manager, by email to Jackie@harmonyplace.on.ca, by fax 416-510-0824, or by mail to 132 Railside Rd. Unit #6 Toronto, ON. M3A 1A3

Part 1: Introduction

Today's Date: __________
(dd/mm/yyyy)

Applicants Name: _____

Address: _____

Phone #: (_____) _____ - _____ ☐Home ☐Cell ☐Work

Additional #: (_____) _____ - _____ ☐Home ☐Cell ☐Work

Email: _____

Date of Birth: _____
(dd/mm/yyyy)

Name of Person(s) Completing Questionnaire: _____

Relationship to Applicant: _____

Reason for Day Program Placement: _____

FOR OFFICE USE ONLY

Start Date: _____ **# Of Days Attending:** _____
(dd/mm/yyyy)

Days Attending: _____

Part 2: Medical Information

Describe the applicant's medical condition and any medical concerns you may have that the program would need to be aware of: _____

_____

Please list all medications with dosages currently being used, and when they are given to the applicant: _____

_____

Does the applicant have seizures? ☐ Y / ☐ N / ☐ History of seizures

If yes, please describe: _____

_____

Does the applicant have allergies? ☐ Y / ☐ N

If yes, please describe: _____

_____

Does the applicant have a g-tube? ☐ Y / ☐ N

If yes, please describe: _____

_____

Part 3: Functional Status

Vision

Does the applicant have any vision impairments? ☐ Y / ☐ N

If yes, please describe: _____

_____

Hearing

Does the applicant have any hearing impairments? ☐ Y / ☐ N

If yes, please describe: _____

_____

Seating & Mobility

Does the applicant have any mobility devices? ☐ Y / ☐ N

If yes, please describe: _____

_____

Is the applicant currently being treated by a physical or occupational therapist?

☐ Y / ☐ N If yes, please describe the service, frequency, and organization used:

_____

_____

Personal Care

Does the applicant need support with personal care? ☐ Y / ☐ N

If yes, please describe (e.g. prompts, transfer, full support):

_____

_____

Meal Intake

Does the applicant need support to eat their meal? ☐ Y / ☐ N

If yes, please describe (e.g. G-tube, full assistance, prompts):

_____

_____

Functional Movement

Please describe the applicant's movement (excellent, good, okay and identify any difficulties).

Hands: _____

Arms: _____

Feet: _____

Legs: _____

Head: _____

Eyes: _____

Communication

Please describe the applicant's current means of communication: _____

_____

If the applicant uses a means of augmentative communication, please explain and describe the system: _____

_____

How does the applicant communicate the following types of messages?

Signal emergency: _____

Request Attention: _____

In Groups: _____

Personal Care: _____

Hunger: _____

Happiness/Pleasure: _____

Anger/Displeasure: _____

Is the applicant currently being seen for communication/speech therapy? ☐ Y / ☐ N

If yes, please describe the service, frequency, and organization used:

_____

_____

Please describe the following about the applicant:

Attention & Behaviour: _____

Attention Span: _____

Approach to Task: _____

Level of Frustration: _____

Motivation: _____

Level of Independence: _____

Inappropriate Behaviours: _____

Part 4: Support & Activities

Who is in the applicants current support network? _____

_____

Is the applicant presently receiving case management services? ☐ Y / ☐ N

If yes, by who- please list contact name, address and phone number:

_____

_____

What activities is the applicant currently involved in? Please list recreational & social activities: _____

What are the applicant's hobbies and interests? _____

_____

Describe any life skill related tasks that the applicant is involved in: _____

_____

_____

What does the applicant hope to achieve by attending HPSS? Are there specific areas the applicant would like to develop?: _____

_____

_____

What can we do to facilitate their learning?: _____

_____

_____

Please check off the greatest areas of interests:

- ☐ Food Related Involvement
- ☐ Computers / iPad
- ☐ Reading / Writing
- ☐ Recreational
- ☐ Art & Crafts
- ☐ Sensory Development
- ☐ Communication
- ☐ Advocacy
- ☐ Life Skills
- ☐ Other (please describe):

Please specify the hours and days the applicant would like to attend Harmony Place:

Monday	☐ AM	☐ PM
Tuesday	☐ AM	☐ PM
Wednesday	☐ AM	☐ PM
Thursday	☐ AM	☐ PM
Friday	☐ AM	☐ PM

Part 5: Transportation

Harmony Place does not provide transportation to or from our programs. Transportation scheduling and any related fees (gas or TTC fare or private transportation, etc.) is the responsibility of the individual and/or their support network unless otherwise indicated. All pick-ups and drop offs must occur between the hours of 8:00 am -4:00 pm.

Will the applicant be using Wheel-Trans? ☐ Y / ☐ N

If yes, Wheel-Trans #: _____ Pin # _____

Password: _____

Please feel free to add any pertinent information that you feel we may require.

Thank you!