

Intake Form



Adventurers Details

Name		Intake Date	
Address			
Email			
Phone		Date of Birth	
Gender	<input type="checkbox"/> Rather not say <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other:		
Status	<input type="checkbox"/> Single <input type="checkbox"/> Boyfriend/Girlfriend <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Defacto <input type="checkbox"/> Divorced		

Main Language Spoken at home	
Country of Birth	
Do you wish to identify as Aboriginal or Torres Strait Islander	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list here any religious / cultural / personal matters that you would like us to be aware of	

Living Arrangements	<input type="checkbox"/> I Live alone <input type="checkbox"/> I Live with my family <input type="checkbox"/> I Live with others
Do you attend other activities during the week (ie: school, work, day programs etc)	

Primary Carer Details

Name		Relationship	
Address			
Email		Phone	

My primary carer is also my emergency contact

Secondary Carer / Emergency Contact Details

Name		Relationship	
Address			
Email		Phone	

Please tell us a little about your other family members / carers / significant others

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Nature of your Disability

Please tell us a little about your disability <i>(Please attach any relevant documentation/referrals)</i>	
Mobility	<input type="checkbox"/> I am Ambulant <input type="checkbox"/> I use a wheelchair <input type="checkbox"/> I use a walker <input type="checkbox"/> Other:
Communication <i>(please tick all that may apply)</i>	<input type="checkbox"/> I am verbal <input type="checkbox"/> I use aids to communicate <input type="checkbox"/> Signing <input type="checkbox"/> Gestures <input type="checkbox"/> I need an interpreter <input type="checkbox"/> I understand all/most things that you say <input type="checkbox"/> Please assist me to read <input type="checkbox"/> Please assist me to write

Is there any other information you would like to tell us?

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Your Medical Information

Doctor Name			
Clinic Name			
Clinic Address	Phone		
Specialist Name			
Specialist Address	Phone		
Medicare No.		HealthCare Card No.	
Companion Card No. & Expiry Date			

Vaccinations	<input type="checkbox"/> I have been double vaccinated against Covid-19 <input type="checkbox"/> I have a medical exemption from Covid-19 vaccination <i>Please provide Adventurebilities with a copy of your vaccination certificate or exemption.</i>
Asthma	<input type="checkbox"/> I have Asthma <input type="checkbox"/> My Asthma Management Plan is attached
Epilepsy	<input type="checkbox"/> I have Epilepsy <input type="checkbox"/> My Epilepsy Management Plan is attached
Diabetes	<input type="checkbox"/> I have Diabetes (Type:) <input type="checkbox"/> My Diabetes Management Plan is attached
Allergies	<input type="checkbox"/> I have Allergies <input type="checkbox"/> My Allergy Management Plan is attached <i>If you do not have an Allergy Management Plan, please tell us a little about your Allergies and how you manage them:</i>

If you require medication assistance while on one of our day or overnight adventures, please provide details	
Do you require PRN (taken as needed) medication while on our adventures? If so, please provide details	
Have you attached your doctor's letter with medication details?	<input type="checkbox"/> Yes, letter is attached <input type="checkbox"/> No, I do not have a letter
If you have other medical conditions that we should know about, please provide details including how they are managed	

All about you

How do you react to new carers?	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> I need some encouragement
How do you react to others	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> I need some encouragement
If you have a sensory object that helps to keep you calm and you would like to bring it on our adventures, please provide details	
If you have any fears, please tell us about them	
Do you have road traffic awareness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I need reminding
Are you aware of stranger-danger and animal-danger?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I need reminding
If you like to wander away or hide, please provide details	
Do you have any risk-taking behaviours? (Lighting fires etc)	
If you are likely to steal from others/shoplift, please provide details	
Do you exhibit inappropriate behaviours? Please tick all that apply	<input type="checkbox"/> Bad Language <input type="checkbox"/> Physical Aggression toward others <input type="checkbox"/> Damage to Property <input type="checkbox"/> Verbally Aggressive toward others <input type="checkbox"/> Sexualised Behaviours <input type="checkbox"/> Disruptive of others

Please provide further details to ensure the safety of participants and staff, including triggers and management for any behaviours

If you have a Behaviour Management Plan, please give us a copy so we can ensure consistent supports with your other support providers

Food and Mealtime Preferences

If you use special aids to use when eating a meal or consuming liquid, or require assistance at meal times please provide details	
If there are any foods/liquids that you cannot have please let us know	
Is there a special reason why you cannot have those foods/liquids?	<input type="checkbox"/> Allergy <input type="checkbox"/> Dislike <input type="checkbox"/> My/Carer Preference <input type="checkbox"/> Other:

Activity Preferences

Are there any sports or other activities that you enjoy either to play or watch?	
Please let us know if you can swim and what your ability is. (If you have had a swimming assessment and hold a consent letter, please provide us with a copy)	<input type="checkbox"/> I can swim <input type="checkbox"/> I cannot swim

Your Routine

In this section we ask you some questions about your support needs for when we go away on overnight adventures to ensure we stick with your usual routines as much as possible. Please answer whatever is appropriate for you.

I can wash my hands	<input type="checkbox"/> Independently <input type="checkbox"/> Please prompt me <input type="checkbox"/> I need assistance <input type="checkbox"/> N/A
I can wash & dry myself	<input type="checkbox"/> Independently <input type="checkbox"/> Please prompt me <input type="checkbox"/> I need assistance <input type="checkbox"/> N/A
I can wash my own hair	<input type="checkbox"/> Independently <input type="checkbox"/> Please prompt me <input type="checkbox"/> I need assistance <input type="checkbox"/> N/A
I can dress myself	<input type="checkbox"/> Independently <input type="checkbox"/> Please prompt me <input type="checkbox"/> I need assistance <input type="checkbox"/> N/A
I can brush my own hair	<input type="checkbox"/> Independently <input type="checkbox"/> Please prompt me <input type="checkbox"/> I need assistance <input type="checkbox"/> N/A
I can brush my teeth	<input type="checkbox"/> Independently <input type="checkbox"/> Please prompt me <input type="checkbox"/> I need assistance <input type="checkbox"/> N/A
I can use the toilet by myself	<input type="checkbox"/> Independently <input type="checkbox"/> Please prompt me <input type="checkbox"/> I need assistance <input type="checkbox"/> N/A
I can shave myself	<input type="checkbox"/> Independently <input type="checkbox"/> Please prompt me <input type="checkbox"/> I need assistance <input type="checkbox"/> N/A
I can manage my menstruation	<input type="checkbox"/> Independently <input type="checkbox"/> Please prompt me <input type="checkbox"/> I need assistance <input type="checkbox"/> N/A
I have bladder control	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I need assistance <input type="checkbox"/> I require continence products Details:
These are my washing preferences	<input type="checkbox"/> Shower <input type="checkbox"/> Bath <input type="checkbox"/> I wash in the morning <input type="checkbox"/> I wash in the evening <input type="checkbox"/> I require washing aids. Details:
I like to go to bed at this time	
I usually get up at this time	
My sleep routine usually includes (please tick all that apply)	<input type="checkbox"/> I find it hard to get to sleep <input type="checkbox"/> I require a night light <input type="checkbox"/> I will bring my CPAP <input type="checkbox"/> I require active overnight support <input type="checkbox"/> I sleep well through the night <input type="checkbox"/> I often do not sleep well and require additional time in the morning to get going

Are there any other details or general comments you would like us to know?

Custody / Legal Arrangements

If there is an Access Alert, Court Order or other Legal Order for yourself or another family member, please provide us with details	
Has a copy of the order been provided to Adventurebilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, what is the reason?)

And finally, how did you find out about Adventurebilities?

Social Media NDIS Provider Register Another Service Family/Friend Support Co-ordinator/Plan Manager

We would like to thank them, please tell us their name: