CLIENT SELF INTAKE FORM

Date of Intake: _____ By: _____

GENERAL INFORMATION

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ St: ___ Zip: _____

Home Phone: _____ Cell Phone: _____

Email:

Preferred Personal Pronouns:

Emergency Contact Name:

Relationship:

_____

Contact Phone Number: _____

Are you a veteran? Yes ◯ No ◯ VA only last 4 digits SSN:

Are you currently or have you ever been a client of the State Department of Rehabilitation? Yes ◯ No ◯

Are you currently employed, looking for employment or hoping to be employed after training?_____

EBC INFORMATION

1. How did you hear about the EBC? _____
2. How did you first contact EBC? _____
3. What is the main reason you contacted the EBC?

_____

4. Source of Referral

- ◯ Assisted living facility
- ◯ Eye care provider
- ◯ Family or friend
- ◯ Independent living center
- ◯ Nursing home
- ◯ Physician / medical provider
- ◯ Self-referral
- ◯ Senior program
- ◯ Social service
- ◯ State VR agency (DOR)
- ◯ VA

Other

- ◯ EBC website
- ◯ Social Media (Facebook, Instagram)
- ◯ Email blast

ABOUT THE CLIENT

5. Race

- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Black or African American
- ◯ Native Hawaiian or Pacific Islander
- ◯ White
- ◯ Did not self-identify
- ◯ 2 or more races

6. Ethnicity

Hispanic or Latino Yes ◯ No ◯

7. Gender

- ◯ Female
- ◯ Male
- ◯ Did not self-identify

8. Primary (preferred) Language:

- ◯ English
- ◯ Spanish
- ◯ Other: _____

9. Living Arrangement:

- ◯ Alone
- ◯ Spouse / Partner
- ◯ Family
- ◯ Roommate
- ◯ Personal Care Assistant

10. Type of Residence

- ◯ Assisted Living Facility
- ◯ Homeless
- ◯ Nursing Home
- ◯ Private Residence
- ◯ Senior Independent Living

11. Do you have stairs to deal with?_____

12. What is your current means of transportation? _____

13. Annual household income level?

- ☐ $0-$25k
- ☐ $25k-$50k
- ☐ $50k-$100k
- ☐ $100k+

☐ **M**edi-**C**al **C**ard?

☐ **M**edicare **C**ard?

14. Do you have any known scheduling Conflicts?

_____

MEDICAL – VISION

15. Degree of Visual Impairment

- ◯ Totally blind
- ◯ Legally blind
- ◯ Severe vision impairment

16. Major Cause of Visual Impairment check **all** that apply:

- ☐ Cataracts
- ☐ Diabetic retinopathy
- ☐ Glaucoma
- ☐ Macular degeneration

17. When did your sight loss begin?

_____

OTHER MEDICAL

18. **Check all Health Conditions:**

- ☐ Alzheimer's Disease / Cognitive Impairment
- ☐ Arthritis
- ☐ Cancer
- ☐ Cardiovascular Disease/Stroke
- ☐ Circulatory Problems
- ☐ Depression/Mood Disorder
- ☐ Developmental Disability/Delay
- ☐ Diabetes Mellitus
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Musculoskeletal
- ☐ Neurological Impairments
- ☐ Psychiatric Disorder
- ☐ Renal Diseases/Genitourinary Disorders
- ☐ Respiratory/Lung Conditions
- ☐ Seizure Disorder
- ☐ Traumatic Brain Injury
- ☐ Other or None

19. Check **all** Other Age-Related Impairments

☐ Hearing impairment

☐ Primary cause of Hearing Impairment: _____

☐ Do you wear a hearing aid?

☐ Mobility impairment

☐ Communication impairment

☐ Cognitive or Intellectual Impairment

☐ Mental Health Impairment

☐ Other impairment: _____