**CLIENT PROFILE**

NAME OF CLIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF REFERRAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENDER; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ETHNICITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELIGION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSONS INVOLVED WITH THE CLIENTS INTERNAL ASSESSMENT:

|  |  |
| --- | --- |
| NAME | REALATIONSHIP TO CLIENT |
|  |  |
|  |  |
|  |  |
|  |  |

DIAGNOSIS:

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

LEVEL OF INTELLECTUAL DISABILITY

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Borderline | Mild | Moderate | Severe | Profound |
| Comments: |

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HEALTH NEEDS:

DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| COMMENTS: |
|  |
|  |
|  |
|  |

VISION:

|  |  |  |  |
| --- | --- | --- | --- |
| Good vision | Reading glasses | General glasses | Assistance with glasses |
| Comments: |

HEARING:

|  |  |  |  |
| --- | --- | --- | --- |
| Good | poor |  Aid required |  Assistance with aid required |
| Comments: |

DENTAL:

|  |  |  |
| --- | --- | --- |
| Own teeth | Dentures | Plate |
| Comments: |

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WHAT ALIMENTS ARE KNOWN THAT THE INDIVDUAL IS PRONE TO?

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

ANY ALLERGIES: THEIR SIDE AFFECTS AND TREATMENT?

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

HISTORY OF EPILEPSY: TYPE OF SEIZURES, SEVERITY AND BEHAVOIURS:

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

DIAGNOSED PSYCHIATRIC ILLNESS: TYPE AND BEHAVIOURS:

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

Please attach any behaviour management, epilepsy or crisis plans.

Page 3

PESONAL HYGIENE

SHOWER / BATH

|  |  |
| --- | --- |
| Independently washes and showers |  |
| Requires verbal prompting to start |  |
| Requires direction during showering |  |
| Requires assistance |  |
| Comments:  |

HAIR CARE:

|  |  |
| --- | --- |
| Independently washes hair |  |
| Requires assistance to wash hair |  |
| Requires checking |  |
| Independently brushes and combs hair |  |
| Requires assistance |  |
| Requires checking |  |
| Comments: |

DRESSING / UNDRESSING:

|  |  |
| --- | --- |
| Can independently choose appropriate clothing for weather |  |
| Can independently choose appropriate colour combination  |  |
| Can independently dress self ( belt buckles, buttons, laces, etc) |  |
| Requires minimal assistance |  |
| Requires total assistance |  |
| Requires checking |  |
| Comments: |

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TEETH:

|  |  |
| --- | --- |
| Independently cleans teeth |  |
| Requires verbal prompting |  |
| Requires assistance to clean teeth |  |
| Requires checking on cleaned teeth |  |
| Comments: |

TOILETING:

|  |  |
| --- | --- |
| Can independently toilet self in familiar surroundings |  |
| Can independently toilet self in community venues |  |
| Can independently toilet self in community venues given verbal assistance or physical assistance to the door |  |
| Requires physical assistance toileting in community venues |  |
| Requires physical assistance toileting at all times |  |
| Comments: |

MENSTRUATION:

|  |
| --- |
| Comments: |

EATING / DRINKING DIETS:

|  |
| --- |
| Comment: |

SLEEP / REST

|  |
| --- |
| Comments: |

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EXERCISE;

|  |
| --- |
| Comments: |

RECREATION; LEISURE; HOBBIES

|  |  |
| --- | --- |
| LIKES: | DISLIKES: |

MOTOR DEVELOPMENT:

|  |  |
| --- | --- |
| Hand / eye coordination |  |
| Grasp  |  |
| Strength |  |
| Fine motor skills |  |
| Run |  |
| Jump |  |
| Posture |  |

MOBILITY / INDEPENDENCE:

|  |  |
| --- | --- |
| Can independently get to and from work |  |
| Can independently get to and from visiting friends |  |
| Requires bus training for new routes |  |
| Requires taxi transport occasionally |  |
| Requires taxi transport other than to work |  |
| Requires taxi transport always |  |
| Can independently move around the home and work place |  |
| Requires physical aids to move around(wheelchair, sick, frame) |  |
| Comments: |

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COMMUNICATION:

|  |
| --- |
| GENERAL (i.e. very good, good, poor, very poor) |
| ABILITY TO CONVEY WISHES: |
| ABILITY TO CONVERY PERSONAL NEEDS (i.e. unwell, pain, help) |
| ABILITY TO EXPRESS EMOTION: (i.e. smiling, crying, expressions) |
| ABILITY TO FOLLOW INSTRUCTIONS: |
| ABILITY TO UNDERSTAND TIME: |

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PERSONAL SAFETY:

|  |  |
| --- | --- |
| Fire drill awareness |  |
| Electrical equipment |  |
| Road skills |  |
| Community awareness |  |
| Comments: |

ORIENTATION IN LOCAL COMMUNITY:

|  |  |
| --- | --- |
| Independence |  |
| Support required |  |
| Ability to seek help |  |
| Knowledge of area |  |
| Toilets  |  |
| Shops |  |
| Bus stops |  |
| Library  |  |
| Comments: |

ABILITY IN UNFAMILIAR SURROUNDINGS:

|  |
| --- |
| Comments: |

SOCIAL AND PERSONAL DEVELOPMENT:

|  |
| --- |
| Comments: |

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**SOCIAL SKILLS**

TELEPHONE SKILLS:

|  |  |
| --- | --- |
| Look up numbers |  |
| Take a message |  |
| Use public pay / card phones |  |
| Use cell phone |  |
| Comments: |

ANTI-SOCIAL CHALLENGING BEHAVIOURS: (identify behaviour and guidance/management of such)

Please attach any management / crisis plans.

|  |
| --- |
| Comments: |

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**DOMESTIC AND HOUSEHOLD SKILLS**

DISHES:

|  |  |
| --- | --- |
| **Can independently wash dishes** |  |
| Requires verbal prompting |  |
| Require physical assistance |  |
| **Can independently dry dishes** |  |
| Requires verbal prompting |  |
| Require physical assistance |  |
| **Can independently stack dishwasher** |  |
| Requires verbal prompting |  |
| Require physical assistance |  |
| **Can independently empty dishwasher** |  |
| Requires verbal prompting |  |
| Require physical assistance |  |

WASHING CLOTHING:

|  |  |
| --- | --- |
| Can independently sort washing |  |
| Can independently put powder in machine  |  |
| Can independently turn machine on |  |
| Requires verbal assistance |  |
| Requires physical assistance |  |
| Can do none of these |  |

VACUUMING

|  |  |
| --- | --- |
| Can independently vacuum as required |  |
| Requires verbal prompting to vacuum |  |
| Requires physical assistance to complete task |  |
| Requires checking on completion of task |  |
| Can do none of the above |  |
| Comments: |

BATHROOM AND TOILETS:

|  |  |
| --- | --- |
| Can independently clean basin and toilet |  |
| Requires verbal prompting |  |
| Requires physical assistance |  |
| Can do none of the above |  |
| Comments: |

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MAKE TEA / COFFEE / MILO:

|  |  |
| --- | --- |
| Can independently make hot drink |  |
| Can make hot drink if kettle is boiled |  |
| Can pour tea once made |  |
| Can do none of the above |  |
| Comments: |

BAKING SKILLS:

|  |  |
| --- | --- |
| Can independently follow simple written recipes and uses hot plates and oven |  |
| Can do the above if recipes are verbally written out |  |
| Requires total verbal direction in all aspects |  |
| Requires verbal and physical assistance |  |
| Can independently use hot plates only |  |
| Will assist with all aspects of baking but can not use hot plates at all  |  |
| Can do none of the above |  |
| Comments: |

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VOCATIONAL / DAY ACTIVITIES / SUPPORTED EMPLOYMENT

|  |
| --- |
| NAME: |
| ADDRESS: |
| PHONE: |
| CONTACT PERSON: |
| COMMENTS: |

|  |
| --- |
| NAME: |
| ADDRESS: |
| PHONE: |
| CONTACT PERSON: |
| COMMENTS: |

|  |
| --- |
| NAME: |
| ADDRESS: |
| PHONE: |
| CONTACT PERSON: |
| COMMENTS: |

|  |
| --- |
| NAME: |
| ADDRESS: |
| PHONE: |
| CONTACT PERSON: |
| COMMENTS: |

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MONEY SKILLS MANAGEMENT:

|  |
| --- |
| Comments: |

ABILITY TO READ / WRITE:

|  |
| --- |
| Comments: |

**FAMILY**

CONTACT WITH FAMILY: (i.e. describe who and relationship level, level of contact etc.)

|  |
| --- |
| Name: |
| Name: |
| Name: |
| Name: |
| Name: |
| Name: |

CLIENT / FAMILY HISTORY:

|  |
| --- |
| Comments: |

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