Holistic Health and Wellness Intake Questionnaire

ADVANTAGE
WHERE HEALTH MEETS HOPE

Date: Name of Individual:

Person completing this form- Title:

Person Providing Information:

Current Services:

Requested Services:

List allergies and what type of reaction do they have. Do they require an epi-pen?

Indicate communication type: Verbal, non-verbal, gestures,etc.

Vision problems: Do they wear glasses? Date of last eye exam

Hearing problems: Do they wear a hearing aid?

Mobility: Can they walk? Are they in a wheelchair? Do they use any type of device (walker, cane, gait belt, hoyer lift or mechanical lift (need MD order prior to service start date). Can they sit upright?

Transferring: Can they step up onto a van safely, do they need assistance if on uneven terrain or unfamiliar terrain or places?

Toileting: Continent of bowel/bladder; incontinent of bowel/bladder. At day, night or both; do they need assistance with hygiene; do they need assistance with their clothing; have they been catheterized in the last year, why? Will they use the bathroom away from home; do they urinate frequently? Are they on a toileting schedule? If so what are the times? If non-verbal how do they let staff know they have to have a bowel movement or urinate? Do they wear a brief or a pull up?

Do they or have they ever had a bowel obstruction or constipation? What year was the bowel obstruction?

Do they wear a helmet? (must have an order every year and prior to start date)

Do they have seizures? What does the seizure look like? How long does it normally last? How long does it take for them to return to baseline? Has the doctor given the seizure a name (Tonic Clonic, Grand Mal, Petite Mal, and Absence?)

What type of diet are they on? Is their diet modified in any way? Do they need their food cut up? Do they require thickener in their liquid? Do they require any type of special devices at meal time? (Must have MD orders) Are they on fluid restrictions (need order)? Loss of appetite, increased appetite, normal appetite? Do they like to drink water or other fluids? Do they have a problem with tasting, smelling? Do they eat very slowly? Do they drool a lot?

Have they ever choked and/or aspirated?

Do they have any type of skin conditions? Dry skin, pressure ulcers, or surgical wounds? If they have an open wound who is caring for it. Who is changing the dressing?

Any surgeries?

Falls – Do they fall often? How many times in a year?

Have they ever had a broken bone from being transferred?

Are they on dialysis? If so where is their graft/fistula located? Which is it a graft or fistula? Graft is man-made. What is the fluid restriction (need order)?

Do they have teeth? Dentures? Gum disease? Any problems chewing? Last Dental Exam- Required for service.

Do they get dizzy when they stand or change positions? Do they have nose bleeds? Last one was? How do we stop them? Do they have very bad headaches?

Do they have swelling in their feet, ankles and legs?

Are they on Oxygen? Intermittent, Constant or PRN – need orders. Orders must have a set order for the O2 flow – 2 Liters per minute – it cannot be 2 to 4 Liters per minute

Do they have a Cpap or Bipap at night? Do they have nebulizer treatments that are to be done at day centers? Orders

Do they have a pacemaker? Who completes the checks and when are the checks completed and when was the last check?

Do they smoke or vape? Do they use other nicotine products?

Do they have sensitivity to heat or cold? Or an aversion to certain textures?

If diabetic will day program have to check blood sugar if so will need orders. Residential will need orders. Are they on insulin? Find out what type and how they take the insulin, if sliding scale get a copy of the sliding scale from family or MD

Do they have a shunt? Find out as much information as you can on the shunt, has it been revised etc.

If Advantage staff is to give medications we need orders for the medications. If they need medications crushed an order is needed. If the medication is liquid there will need to be an MD order.

If they have a residential provider outside of Advantage, Health Care and Safety Plans will be required. Date required by:

A copy of the most recent physical or ABHS physical form returned. Date Required by:

Current sleep routine: How many hours of sleep a night? Bedtime/wake time?

Current triggers and behavioral results, ie: if “outbursts” are reported, what are the specific behaviors. How long do they last? Able to deescalate? How?

Current Mental Health Diagnosis and Mental Health medications

History of Mental Health Diagnosis

Current behavioral needs/concerns

Current/history of legal trouble

History of Mental Health hospitalizations- Crisis Team Calls? When, Where & Why

Current Doctors

Perfect/Ideal day

Likes/Dislikes

What is important to/for individual

Needs daily assistance with

Preferred/Requested schedule

Ideal Staff

Residential Needs

CA Needs

Any other information to consider:

Current HRST Score: Current SIS Score:

- Will need copy or access: ISP, HRST, SIS, Nursing Assessment, Behavioral Assessment, Social Work Assessment

Recommendations of Program:

Date Sent to Nurse, Day Services Manager, IDD Director & Residential Manager:

Date Reviewed by IDD Leadership:

Outcome of Review and Next Steps:

Approved /Denial (reason) Date

Signature of Leadership Review/Title: