Lighthouse
Disability Ministries

Intake Form

Our goal is to provide a respite time for you and your family. We desire to give your loved one the attention needed to make coming to Lighthouse Disability Ministries Inc. a joyful experience. We have included many areas of assessment, *please fill out only those areas that pertain to your loved one.* Thank you for helping us be able to serve your family better.

If there is any information you would like to keep private, please let us know. Thank you.

Please fill out parent/guardian information here.

First Name: _____ Last Name: _____

Full Address: _____

Phone: _____ Email: _____

Please fill out attendee's information here.

First Name: _____ Last Name: _____

Full Address: _____

Birth date: _____ Gender: _____

Disability or Special Need: _____

_____

Behavioral Information (Check All That Apply):

☐ Anxious ☐ Hyperactive ☐ Plays Well Alone ☐ Plays Well In Group

☐ Transitions Easily ☐ Transitions with Difficulty ☐ Prefers Verbal Instructions

☐ Prefers Visual Instructions ☐ Responds Well to Correction

☐ Responds to Correction with Difficulty ☐ Can Become Aggressive

☐ Sometimes Runs Away ☐ Sensitive to Noise ☐ Shy ☐ Outgoing

List other sensitivities: _____

_____

My child's strengths are: _____

_____

My child is best comforted by: _____

_____

My loved one lets me know what he/she wants by: _____

_____

Describe a potential behavior issue your loved one may exhibit while in our care:

_____

What happens prior to, or what often causes, this behavior? Is it usually caused in response to something else? _____

_____

What cues are noticeable prior to the behavior: _____

_____

What is the best way to redirect this behavior: _____

_____

What is a positive reinforcement that is effective with your loved one, that can be done while in our care? _____

_____

Physical Information (Check All That Apply):

☐ Impaired Vision ☐ Blind ☐ Impaired Hearing ☐ Deaf ☐ Needs Assistance with Sitting
☐ Needs Assistance with Walking ☐ Uses Crutches or Braces ☐ Uses a Walker
☐ Uses a Wheelchair

Please describe any special positioning needs your loved one may have: _____

_____

Seizures: ☐ Yes ☐ No

If yes, please give us more details on what to look for and how to respond: _____

_____

Dietary Restrictions: ☐ Yes ☐ No

If yes, please explain further: _____

Forms of Communication (Check All That Apply):

☐ Speech ☐ Gestures ☐ Sign Language ☐ Communication Device

Can Understand What Others Say:

☐ All of the Time ☐ Most of the Time ☐ Some of the Time

Please let us know how to best communicate with your loved one: _____

_____

Toileting Information:

☐ Independent ☐ Currently Toilet Training ☐ Needs Assistance

How does your loved one indicate a need to use the bathroom: _____

_____

Additional Information:

What are some of your loved ones favorite things: _____

_____

Please tell us anything else you think we should know about your loved one: _____

_____

How can we pray for your family: _____