



Intake Form

Date of Intake: _____

Client Information

Full Name: _____

Date of Birth: _____ Age: _____

Gender: _____

Address: _____

Phone Number: _____

Email Address: _____

Primary Contact Information

Parent/Guardian Name(s): _____

Relationship to Client: _____

Phone Number: _____

Email Address: _____

Emergency Contact Information

Emergency Contact Name: _____

Relationship to Client: _____

Phone Number: _____

Client Background

1. Diagnosis/Disabilities:

2. Allergies/Medical Conditions:

3. Medications:

4. Current Therapies (if any):

5. Previous Skills Training (if any):

Areas of Focus and Goals

1. What specific life skills do you want your child/loved one to work on? (Please check all that apply):

Daily Living Skills

- ☐ Personal Hygiene (e.g., brushing teeth, combing hair)
- ☐ Meal Preparation (e.g., making a snack, using utensils)
- ☐ Laundry and Dressing (e.g., sorting clothes, managing zippers)

Community Integration Skills

- ☐ Dining Etiquette (e.g., ordering at a restaurant, using utensils)
- ☐ Shopping Skills (e.g., grocery shopping, handling money)
- ☐ Public Transportation (e.g., reading schedules, purchasing tickets)

Home Management Skills

- ☐ Cleaning and Organization (e.g., sweeping, organizing personal space)
- ☐ Money Management (e.g., budgeting, managing a bank account)

Communication Skills

- ☐ Verbal Communication
- ☐ Nonverbal Communication (e.g., using AAC devices, PECS)
- ☐ Social Interaction (e.g., making friends, group activities)

Other Skills:

2. Are there any specific areas of deficiency that you believe need special attention?

3. What goals would you like to see achieved through our program?

Short Term Goals (e.g., mastering a specific task within the next few months):

Long Term Goals (e.g., increasing overall independence, preparing for future transitions):

Client's Preferences and Comfort Levels

1. What are your child's/loved one's favorite activities or interests?

2. Are there any activities or situations that cause anxiety or discomfort?

3. Does the Client use any adaptive equipment or technology (e.g., communication devices, mobility aids)?

4. How does your child/loved one best learn new skills? (e.g., visual aids, hands-on practice, repetition)

Additional Information

Is there anything else we should know to better support your child/loved one?

Consent and Agreement

I, the undersigned, agree to the intake of the Client into Saint Kat's WheelHouse Academy. I understand the nature of the programs offered and consent to the participation of my child/loved one in the life skills training and other activities provided by the academy.

I acknowledge that while the academy will strive to provide the best possible training and support, mastering the skills taught is not guaranteed. I also acknowledge and agree that Saint Kat's WheelHouse Academy and its employees, agents, and representatives shall not be liable for any injury, loss, or damage to my child/loved one or their property, whether caused by the negligence of the academy, its employees, agents, or representatives, or otherwise, except as required by law.

I further represent and warrant that I have the legal authority to act as the guardian of the above-named child/loved one and the legal right to provide consent on their behalf.

I understand that it is my responsibility to inform the academy of any specific medical conditions, allergies, or other factors that may impact the safety or wellbeing of my child/loved one.

Parent/Guardian Signature: _____ Date: _____

Client Signature: _____ Date: _____

Owner Signature: _____ Date: _____

