ADAPTIVE BEHAVIOR SUMMARY

Consumer Name: _____ Consumer's Date of Birth: ___/___/___

Checklist completed by: _____ Consumer's MIS #/ DDD Serial #: _____

Relationship to Consumer: _____ Date Completed: _____ Phone: _____

I. MEDICAL INSURANCE & BIRTH INFORMATION

MEDICAID Number #	MEDICARE Number #	PRIVATE CARRIER Name, Policy and Telephone # # ( ) -

BIRTH HOSPITAL	CITY/STATE	COUNTY (If in NJ)	COUNTRY (If outside of USA)

II. PARENT INFORMATION & EMERGENCY CONTACTS

MOTHER	Name		Home Phone	Work Phone
Full Address				Emergency Contact? ☐ Yes ☐ No
Date of Birth	Social Security #	Marital Status/Maiden Name	Veteran? ☐ Yes ☐ No	Mother Deceased? ☐ Yes ☐ No
FATHER	Name		Home Phone	Work Phone
Full Address				Emergency Contact? ☐ Yes ☐ No
Date of Birth	Social Security #	Marital Status/Maiden Name	Veteran? ☐ Yes ☐ No	Mother Deceased? ☐ Yes ☐ No
Other Relation?	Name		Home Phone	Work Phone
Full Address				Emergency Contact? ☐ Yes ☐ No
Other Relation?	Name		Home Phone	Work Phone
Full Address				Emergency Contact? ☐ Yes ☐ No

III. OTHER SOURCES OF INFORMATION

In order to make a decision on eligibility or to properly serve the applicant after eligibility is established, more information must sometimes be obtained. Please list the names and addresses of other sources of information (such as school programs, child study teams, or other agencies) who have records relating to the applicant's disability that you feel we should know about.

NAME/CONTACT PERSON	ADDRESS	CITY/STATE	TELEPHONE	WHEN INVOLVED?
				☐ Past ☐ Current
				☐ Past ☐ Current
				☐ Past ☐ Current

IV. ADDITIONAL COMMENTS

Is there other information you have not listed that you feel we should know about this person? Please attach additional of paper if necessary. Thank you for your assistance.

V. COMMUNICATION SKILLS

1. Please list the languages used by this person: _____

2. Understands the spoken word? ☐ Yes ☐ No
3. Follows simple directions? ☐ Yes ☐ No
4. Any hearing problems? ☐ Yes ☐ No
5. Communicates through: ☐ Yes ☐ No
a. Verbal speech ☐ Yes ☐ No
b. Communication device ☐ Yes ☐ No
c. Gestures ☐ Yes ☐ No
d. Signs ☐ Yes ☐ No

Gestures and signs known and used: _____

6. Dials and speaks over the telephone? ☐ Yes ☐ No
7. Can this person read? ☐ Yes ☐ No
8. Can this person write? ☐ Yes ☐ No

VI. SOCIAL BEHAVIORS

9. What does this person enjoy doing? _____

10. How are emotions such as anger or frustration displayed? _____

11. Is this person sexually active? ☐ Yes ☐ No Comments: _____

12. How are symptoms of illness communicated? _____

13. Does this person smoke? ☐ Yes ☐ No Comments: _____

14. Are there any unusual fears? (list): _____

15. Does this person

a) Wander off if not closely supervised? ☐ Yes ☐ No

b) Run away? ☐ Yes ☐ No

c) Have any unusual sleep patterns? ☐ Yes ☐ No

16. Can this person be in a home with children? ☐ Yes ☐ No
17. Is this person
    a) Self-abusive ☐ Yes ☐ No If yes, how? _____
    _____
    b) Abusive to others? ☐ Yes ☐ No If yes, how? _____
    _____
    c) Destructive to property? ☐ Yes ☐ No If yes, how? _____
    _____

VII. COMMUNITY AWARENESS

18. Does this person attend a Day Program? ☐ Yes ☐ No If yes, give program name, address and contact: _____
_____
19. What community activities are enjoyed? _____
_____
20. Does the person demonstrate appropriate behavior during these activities? ☐ Yes ☐ No If no, comment: _____
_____
21. Is this person aware of ordinary household dangers, such as stairs, heaters, electric outlets, household cleaners, ovens, wood burning stoves and fireplaces? ☐ Yes ☐ No ☐ No opportunity to observe If no, specify: _____
_____
22. Does this person demonstrate awareness of community dangers, including traffic, being overly friendly with strangers, ☐ Yes ☐ No ☐ No opportunity to observe If no, specify: _____
_____
23. Can the consumer count change/make purchases? ☐ Yes ☐ No ☐ Only under supervision
24. Can this person tell time? ☐ Yes ☐ No ☐ to the hour ☐ to half hour ☐ to quarter-hour

VIII. SELF-HELP SKILLS (Check appropriate boxes)

A. TOILETING

25. Does this person wear diapers/continency garments? ☐ Yes ☐ No If yes, when ☐ Day ☐ Night
    (If continency garments are worn, please skip to section B. HYGIENE)
26. Appropriate toilet habits? ☐ Yes ☐ No If no, specify: _____
_____
27. Any bladder accidents? ☐ Yes ☐ No If Yes, ☐ Day ☐ Night (how often)?
28. Any bowel accidents? ☐ Yes ☐ No If Yes, ☐ Day ☐ Night (how often)?
29. Toilets self independently? ☐ Yes ☐ No If No, what kind of help is needed? _____
_____
30. Wipes self with toilet paper? ☐ Yes ☐ No ☐ Only if reminded ☐ Only if verbally directed ☐ Only with physical assistance
31. Washes hands after toileting? ☐ Yes ☐ No ☐ Only if reminded ☐ Only if verbally directed

☐ Only with physical assistance

32. Takes care of menstrual? ☐ Yes ☐ No ☐ Only if reminded ☐ Only if verbally directed

☐ Only with physical assistance

B. HYGIENE 33. Washing and Bathing	Independent	Needs to be reminded	Needs verbal direction	Needs physical assistance	No opportunity to observe	**Comments**
a) Washes and dries hands						
b) Washes and dries face						
c) Bathes self in bathtub						
d) Showers self						
e) Turns on & regulates water temperature						
f) Washes hair						
g) Dries self						
34. Uses deodorant						
35. Combs/brushes hair						
36. Tooth and Mouth care						
a) Brushes own teeth						
b) Puts toothpaste on brush						
37. Dentures						
a) Worn regularly						
b) Cares for own dentures						
38. Blows and wipes own nose w/ tissue						
39. Shaving (usually uses) ☐ Safety razor ☐ Electric razor						
C. DRESSING SKILLS 40. Undresses self						
41. Buttons						
42. Snaps						
43. Zippers						
44. Fastens a buckle						
45. (Women) Hooks own bra						
46. Ties shoes						
47. Dresses self completely						
48. Changes clothing regularly						
49. Matches colors/patterns						
50. Selects seasonal clothing						
D. EATING 51. Feeds self with spoon						
52. Feeds self with fork						
53. Cuts food with a knife						
54. Eats with fingers						
55. Drinks from a cup or glass						

56. Any favorite foods?

Consumer Name: _____ Date Completed: _____

Checklist completed by: _____ Phone: _____

IX. PHYSICAL CONDITIONS, LIMITATIONS, AND ASSISTIVE DEVICES

51. Are G-tube feedings given? ☐ Yes ☐ No

52. Is any adaptive feeding equipment used? ☐ Yes ☐ No

If yes, Specify:

_____
_____
_____
_____

53. Is this person on a special diet? ☐ Yes ☐ No

If yes, what kind? ____ Low Salt ____Low Sugar____ Low Cholesterol ____ Chopped Food

____ Pureed Food ____Other _____

54. If any foods must be avoided because of allergies, digestive problems, religious considerations, or dislike, please list:

_____
_____
_____

55. Please check all the medical problems or related conditions that you are aware of:

	Current	History of Problem
a) Asthma	_____	_____
b) Diabetes	_____	_____
c) Frequent Colds	_____	_____
d) Pneumonia	_____	_____
e) Lung/Breathing Problems	_____	_____
f) Seasonal Allergies/Other	_____	_____
g) Ear infections	_____	_____
h) Frequent headaches	_____	_____
i) Serious skin problems	_____	_____
j) Gum Problems	_____	_____
k) Dental Problems	_____	_____
l) Hypertension	_____	_____

m) Heart/Circulatory Problems _____ _____

n) Stomach/Digestive Problems _____ _____

o) Kidney/Urinary Problems _____ _____

p) Pica (eats inedible objects) _____ _____

q) Hepatitis B Carrier _____ _____

r) Seizure Disorder _____ _____

(check type which affects consumer):

_____ Loss of consciousness/Grand Mal/Tonic-Clonic

_____ Absence, or staring episodes/Petit Mal

s) Other medical problems (List):

_____

_____

_____

56. Is this person visually impaired? ☐ Yes: _____ ☐ No

57. Check which of the following best describes mobility:

- ☐ Walks independently, with or without physical aids
- ☐ Primarily uses a wheelchair, but can move and transfer in and out of it independently
- ☐ Can move the wheelchair independently, but needs assistance with transfers
- ☐ Non-Mobile, totally dependent

58. Height: _____ Weight: _____

59. Please indicate which of the following the person owns and uses:

☐ Manual wheelchair	☐ Eyeglasses
☐ Motorized wheelchair	☐ Hearing aid
☐ Stroller	☐ Helmet
☐ Walker	☐ Scoliosis Jacket
☐ Crutches	☐ Elastic stockings
☐ Cane	☐ Braces (AFO, KAFO, etc.)
☐ Corrective shoes	☐ Dental appliances
☐ Car seat	☐ Other: (list) _____

_____

60. Please list all medications taken on a regular basis:

MEDICATION	DOSAGE/TIMES TAKEN	TO CONTROL	PHYSICIAN

61. Method of administering medications (describe how independent the consumer is in administering own medications:

62. Allergies to any medications and or other substances? ☐ Yes ☐ No Specify: _____

X. CURRENT PHYSICIANS

PHYSICIAN TYPE	NAME	ADDRESS	TELEPHONE
Primary			