



*A Comprehensive Program  
for People with Cognitive  
Disability*

Participant's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Parent/Guardian names: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Numbers Home: \_\_\_\_\_

Cell: \_\_\_\_\_

Other: \_\_\_\_\_

Email: \_\_\_\_\_

DDD Case Support Coordinator Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email address: \_\_\_\_\_

Other Emergency Contact Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

**Preferences**

Likes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Dislikes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



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**Personal care skills** *(Check all applicable items)*

	Dressing	Toileting	Eating	Dental	Menses
Independent					
Requires prompting/ reminding					
Requires limited assistance/ supervision					
Requires significant assistance					

Additional Comments:

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**Behavioral Concerns**

*(Check the appropriate yes/no boxes. If yes, complete last 2 columns)*

	No	Yes	Describe behavior	Frequency
Aggression				
Self-injurious				
Injurious towards others				
Property destruction				
Unusual or repetitive behavior				
Self stimulating (stemming)				
Running away				
Sexual acting out				
Other				

Additional Comments:

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**Social/emotional development** *(Check all that apply)*

- |  |  |
|--|--|
| <input type="checkbox"/> Is relatively free from signs of problems   | <input type="checkbox"/> Interacts appropriately with caregivers |
| <input type="checkbox"/> Expresses feelings:<br><input type="radio"/> Verbally<br><input type="radio"/> Non-verbally | <input type="checkbox"/> Interacts appropriately with peers      |
| <input type="checkbox"/> Initiates cooperative interactions  | <input type="checkbox"/> Interacts appropriately with animals    |
| <input type="checkbox"/> Is usually even-tempered  |  |
| <input type="checkbox"/> Shows anger appropriately   | Prefers the company of:  |
| <input type="checkbox"/> Doesn't interact, even when encouraged  | <input type="checkbox"/> Males                                   |
| <input type="checkbox"/> Resists cooperation   | <input type="checkbox"/> Females                                 |
| <input type="checkbox"/> Appears to have significant emotional problems  | <input type="checkbox"/> Children                                |
|  | <input type="checkbox"/> Adults                                  |
|  | <input type="checkbox"/> No preference noted                     |

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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**Medical Concerns** *(check all applicable items)*

- No chronic medical problems-basically healthy
- Hearing impairment (describe): \_\_\_\_\_
- Vision impairment (describe): \_\_\_\_\_
- Seizure disorder (type):
  - Petit mal
  - Grand mal
  - Focal
  - Psychomotor
  - Completely controlled with medication
  - Somewhat controlled with medication
  - Not controlled with medication
  - Unusual behavior before seizure (describe): \_\_\_\_\_  
\_\_\_\_\_
  - Unusual behavior after a seizure (describe): \_\_\_\_\_  
\_\_\_\_\_
- Specific dietary needs (describe): \_\_\_\_\_
- Allergy to food (describe): \_\_\_\_\_
- Allergy to bee stings (describe): \_\_\_\_\_
- Allergy to medications (describe): \_\_\_\_\_

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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**Communication Skills** *(Check all that apply)*

Communication Mode:

- Verbal
- Communication Device
- Sign
- Gesture
- No system to indicate wants and needs

Expressive Language:

- No problems with articulation
- Single words
- Phrases and/or short sentences
- Asks for assistance when needed
- Problems with articulation

Receptive Language:

- Understands what is being said
- Makes eye contact
- Follows one-step instructions
- Follows multi-step instructions

Additional Comments:

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The information included in this document is confidential and will only be used by One Step Beyond, Inc. for enrollment purposes. My signature verifies that all of the information is true and valid to the best of my knowledge.

Signature from Participant: \_\_\_\_\_

Date: \_\_\_\_\_

Signature from Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_