Easter Seals

Rural Solutions

Independent Living Assessment

Client's Name ____

Intake Date __________________________

Applicant's name ____
Last First Middle

Current address

____
Street City County State Zip

Telephone number ______________________________ Cell phone ____________________________________

E-mail address _________________________________ Social Security number ________________________

Date of birth _________________________________ Gender ☐ Male ☐ Female

Referral Source (if applicable)

____
Name Agency Telephone Number

Why are you interested in Easter Seals? How can Easter Seals help you?

____

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____

Military status

☐ Member of Military/Veteran family (child, spouse, parent)

☐ National Guard/Reserve ☐ Veteran ☐ N/A

Marital status

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Significant other

Number of children ☐ None ☐ 1 to ____________

Living arrangements ☐ Lives alone ☐ Lives with another person(s)

List name(s) and relationship

____

____

Onset of disability ☐ Sudden onset, date ______________________ ☐ Gradual decline

Cause of disability ____

Description of disability (cause of disability and limitations)

____

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____

Tell us about yourself and your farming operation

____

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Do you require alternative format documents (large type, Braille, etc.) or utilize alternative communication (i.e., sign language)? ☐ Yes ☐ No

Client's Name ____

Type of Disability at time of referral (check ONE)

Diseases of the Nervous System & Sense Organs - 1006

☐ Alzheimer's

☐ Parkinson's

☐ Multiple Sclerosis

☐ Cerebral Palsy

☐ Epilepsy

☐ Other Peripheral Nervous System

☐ Muscular Dystrophy

☐ Disorders of the Eye – Blindness – Low vision/Deafness/Conductive

☐ Diseases of the Ear/ Hearing Loss/Perceptual Auditory

Diseases of the Circulator System – 1007

☐ Heart Disease

☐ Stroke

☐ Other Diseases of the Circulatory System

Diseases of the Respiratory System – 1008

☐ Emphysema

☐ Asthma

☐ Chronic Obstructive Pulmonary Disease

☐ Other Diseases of the Respiratory System

Diseases of the Digestive System – 1009 i.e. Colitis, Hernia etc.

☐

Diseases of the Genitourinary System – 1010 i.e. Nephritis, Chronic Renal Failure

☐

Diseases of the Skin & Subcutaneous Tissue – 1012 i.e. Eczema, Cellulitis, etc.

☐

Diseases of the Musculoskeletal System & Connective Tissue – 1013

☐ Lupus

☐ Osteoporosis

☐ Arthritis – Osteoarthritis/

Rheumatoid Arthritis

☐ Scoliosis

☐ Other Diseases of the Musc. System & Connective Tissue –

Other Disabilities – 1019 ☐

Frail Elderly – 1020 ☐

Well Elderly - ☐

Obesity - ☐

Disadvantage - ☐

Uknown -☐

Congenital Anomalies - 1014

☐ Spina Bifida

☐ Cleft Palate

☐ Down's Syndrome

Certain Conditions Originating in the

Perinatal Period – 1015 i.e. Fetal Alcohol Syndrome, Drugs, Cocaine, Narcotics, Some Premature Conditions

☐

Symptoms, Signs & Ill-Defined Conditions – 1016

☐ Speech Language & Voice Dysfunction

☐ Other Symptoms Signs & Ill-Defined Conditions – Chronic Fatigue/ Dysphagia/Debility/Aphasia/Cleft Palate/Lip/Dysarthria

Disease to Bone/Joint – 1017

☐ Spinal Cord Injury

☐ Head Injury

☐ Other Disease or Injury to Bone or Joint – Contractures/Degeneration/ Fratures/Dislocations/Amputation/

Strains/Sprains/Whiplash/Burns

Non Disabled – 1018

Client's Name ____

	Specific Disability Type	
Infectious & Parasitic Disease – 1001 ☐Post polio Syndrome ☐Tuberculosis ☐Viral Hepatitis ☐Meningitis ☐Rheumatic Fever or disease ☐Rubella, Rubcola ☐AIDS Neoplasm's – 1002 ☐Cancer ☐Leukemia	Endocrine, Nutrutional & Metabolic Diseases & Immunity Disorder – 1003 ☐Diabetes ☐Dwarfism ☐Disorders of the Thyroid ☐Cystic Fibrosis ☐Renal Disorders ☐Dental Disorders	Mental Disorders – 1005 ☐Dementia ☐Autism ☐Alcoholism/Drug Abuse ☐Psych Disorders – personal/family ☐ADD/ADHD ☐Developmental Delays - speech/reading/learning/language ☐Other Mental disorders– Behavioral ☐Mental Retardation

Additional details re: disability:

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Signature of person completing form ____

Date ____