RE: Developmental Disabilities Intake

In order to determine eligibility for services, you will need to provide our agency with the following documents and information:

- ☐ Copy of most recent IFSP or IEP from school.
- ☐ Copy of most recent school assessment.
- ☐ Copy of medical exam, completed and signed by your pediatrician or primary doctor, exam done within the last 12 months. A form is enclosed for you to use, but information is not required to be on this form.
- ☐ Current IQ assessment (done within last three years). (May be a part of the IFSP or IEP.)
- ☐ Social and Developmental History Questionnaire (enclosed), completed.
- ☐ Mental Health Diagnostic Assessment Consent for Release form, signed (allows Blue Earth County to obtain most recent mental health information from the mental health practitioner).
- ☐ Other documentation of disability from other agencies.

Information can be returned to our agency, Attention: Colleen Fitzpatrick. If you have any questions about this request or services that could be provided, please call (507) 304-4444.

DDL.11(1)

BLUE EARTH COUNTY HUMAN SERVICES
MEDICAL EXAMINATION FORM

Name of Patient:		Date of Examination:
Current Age	Height	Weight
Diagnosis		

	√ below if normal	If abnormal, explain
Skin: Scalp Feet		
Ears: Inner Outer Hearing		
Vision: organ acuity		Referred to Otologist? ____ Audiologist? ____
Coordination: (e.g., nystagmus stradismus)		Referred to Oculist?
Nose Teeth		
Throat		
Abdomen		
Back		Scoliosis? _____ Kyphosis?_____
Lungs		Muscle Tone:
Nervous System		Referral to Neurologist?
Heart: Blood Pressure Hemoglobin		
Urinalysis		
Hernia: Genitals Pap Smear		

Allergies	Mantoux Test Chest X-ray ☐ Negative ☐ Positive
Has applicant had surgery? ☐ No ☐ Yes (type/date/where)	

Has applicant had a past history of:

☐ Arthritis
☐ Heart Disease
☐ Seizures: Controlled?_____
☐ Diabetes
☐ Emotional Disturbance
☐ Other:_____

This client has been tested for:

☐ Hepatitis B. Date:_____ Test taken? ☐ Yes ☐ No
Results: ☐ Positive ☐ Negative

Is applicant being treated for any of the above? ☐ No ☐ Yes If yes, please list treatment, date, and doctor.

_____

_____

_____

Should there be any restrictions on activity? ☐ No ☐ Yes If yes, what kind?_____

_____

Current Medication	When Initiated	Reason for Medication	When to be Evaluated

_____ _____
Print Name Examining Physician's Signature

_____
Address

Blue Earth County
Social History Questionnaire

I. Identifying Information (regarding applicant/child)

Name	
Present Address	
Phone Number	Home: Work: Cell:
Birth Date and Age	
Birth Place	
County of Residence	
Guardianship Status	☐ Minor ☐ Independent Adult ☐ Under Guardianship
Marital Status	
Relative Contact Person (Name and Address)	

II. Insurance and Financial Information

Social Security Number	
Private Health Insurance Provider ☐ N/A	ID #_____ Group #_____
Medical Assistance Number ☐ N/A	
Financial Worker Name	
Medicare Number ☐ N/A	
Social Security Income (SSI) ☐ N/A	Monthly Amount:
Retirement, Survivors, Disability Income (RSDI) ☐ N/A	Monthly Amount:
Child Support ☐ N/A	Monthly Amount:

III. Appearance

Height	
Weight	
Eye Color	
Hair Color	
Identifying Marks	
General Statement of Appearance (i.e. appears younger than is)	

IV. Birth and Early Development (complete only for Applicant 10 and younger)

Birth order and number of siblings		
Mother's _____ pregnancy, any difficulties?		
Full term? Normal delivery? Labor induced? (describe complications)		
Birth weight	☐ Premature ☐ Full term ☐ Overdue	
General appearance		
Infant's personality and activity level		
Were there any previous or subsequent miscarriages?		
Developmental activities	First sat up alone	
	First crawled	
	Walked	
	Talked	
	Toilet-trained	
When developmental lags became evident (first suspicions of slow development)		
When was developmental delay confirmed and by who?		
Infant's health – any high fevers, disease, falls, or accidents?		

V. Family Background

A.	Parent's current marital status (married and living together, separated, divorced, widowed, etc.)	

B. Father

Full Legal Name	
Birth Date	
Address	
Phone	
Custody of Minor Applicant	☐ Physical Custody ☐ Legal Custody ☐ N/A
Current Employment	

C. Mother

Full Legal Name	
Birth Date	
Address	
Phone	
Custody of Minor Applicant	☐ Physical Custody ☐ Legal Custody ☐ N/A
Current Employment	

D. Other Caregiver ☐ **Stepparent** ☐ **Grandparent(s)** ☐ _____

Full Legal Name	
Birth Date	
Address	
Phone	
Education	
Current Employment	
Date assumed custody/caregiver role	

E. Sibling(s)

Name			
Birth Date - Age			
Phone			
Address			

F. ☐ **Guardian** ☐ **Power of Attorney** ☐ **Representative Payee**

Full Name(s)	
Address	
Phone	
Date Established	

VI. Medical History

A. Applicant

Diagnoses	
Present Health Status	
Most recent general physical exam	Date: _____ By Whom:_____
History of Past Illnesses and Hospitalizations:	
Date	Hospital
Reason	
Date	Hospital
Reason	
Seizure disorder	☐ Yes ☐ No Controlled? ☐ Yes ☐ No
When did the seizures begin?	
Type of seizures, frequency, severity of seizures	
Current medications and reason for taking Medication:_____ Reason:_____ Medication:_____ Reason:_____ Medication:_____ Reason:_____	
Allergies or sensitivities	
Vision Problems	☐ Yes ☐ No If yes, specify
Hearing Problems	☐ Yes ☐ No If yes, specify
Mobility	☐ Ambulatory ☐ Uses wheelchair ☐ Ambulates with device_____ ☐ Not mobile. Why:_____

B. Family Medical History

Is individual adopted?	☐ Yes ☐ No
Father: Indicate any significant health issues (diabetes, heart disease, cancer, high blood pressure, etc.)	
Paternal (immediate and extended) history of disability (indicate diagnosis) ☐ N/A	
Mother: Indicate any significant health issues (diabetes, heart disease, cancer, high blood pressure, etc.)	
Maternal (immediate and extended) history of disability (indicate diagnosis) ☐ N/A	
Any other health-related information	

C. Medical Providers

Doctor (primary practitioner)	Name	
	Clinic Name	
	Address	
	Phone #	
	Date last seen	
Neurologist ☐ N/A	Name	
	Clinic Name	
	Address	
	Phone #	
	Date last seen	
Optometrist/ Ophthalmologist ☐ N/A	Name	
	Clinic Name	
	Address	
	Phone #	
	Date last seen	

Dentist ☐ N/A	Name	
	Clinic Name	
	Address	
	Phone #	
	Date last seen	
Other Specialist – Name type	Name	
	Clinic Name	
	Address	
	Phone #	
	Date last seen	

VII. Other Services

A. List any other Services and the Provider:

Service:	Service:
Provider:	Provider:

B. What are your typical activities during the day?

C. Does client currently have a vocational counselor from the Department of Vocational Rehabilitation (DRS)?

Name	
Phone Number	
Address	

VIII. Residential History (cities where application has lived and approximate dates)

City/Place	Dates: From - To

IX. Employment History (if applicable)

Current Job

From – To	Employer	Job	Hours Worked	Wage/Hour

Previous Jobs

From – To	Employer	Job	Hours Worked	Wage/Hour

X. Functional Skills

A. Communication

Primary language at home	
1. Expressive	☐ Functional Language ☐ Intelligible to familiar listeners ☐ Difficult to understand ☐ Uses alternative form (i.e. visual, gesture) ☐ Unable to make wants/ needs known ☐ and is typical given age
2. Receptive	☐ Comprehends verbal communication ☐ Needs additional processing time ☐ Limited comprehension ☐ Comprehends alternative form ☐ Does not comprehend verbal, visual, or gestured communication (i.e. visual, gesture) ☐ and is typical given age
What is the preferred method of communication for this individual?	☐ Verbal ☐ Signs and/or gestures ☐ Augmentative communication device ☐ Other_____

Key:

Independent: Able to initiate and perform task with no prompting (would complete all steps with no one present)
Needs Verbal Assistance: Verbal prompts or gestured cues required for individual to initiate and/or perform task
Needs Physical Assistance: Requires direct assistance to initiate and/or perform task
Totally Dependent: Totally reliant on caregiver to perform task
N/A due to age: Not typical for child to perform task at current age or gender

*More than one answer may be appropriate to check.

B. Self-Care Capabilities

1. Mastery of self-care skills (check appropriate boxes, short comments helpful)

	Independent	Needs verbal assistance	Needs physical assistance	Totally dependent	NA
Eating					
Dressing – dress self					
Dressing – can choose day's clothes					
Toileting					
Bath/shower with soap					
Tooth-brushing					
Comb and brush hair					
Shampoo and rinse hair					
Personal hygiene use, deodorant, shaving					
Menstrual needs (if applicable)					
Birth control					

2. Describe sleeping habits of the person:

_____

_____

C. Survival Skills (check appropriate area, short comments helpful)

	Independent	Needs verbal assistance	Needs physical assistance	Totally dependent	NA
Avoids simple dangers					
Knows address, telephone number					
Knows route home					
Would ask for help/seek police					
Can tell time					
Can dial phone					
Knows street safety, crosses with lights, etc.					
Can identify correct restroom					
Ability to communicate pain, illness injury, or abuse					

D. Independent Living Skills (check appropriate boxes, short comments helpful)

	Independent	Needs verbal assistance	Needs physical assistance	Totally dependent	N/A
Household cleaning					
Laundering/clothing care					
Administer own medication					
Make medical/dental appointment					
Safety in kitchen					

	Independent	Needs verbal assistance	Needs physical assistance	Totally dependent	N/A
Safety/knows and/or carries emergency phone numbers and can use					
Diet/nutrition planning					
Cooking					
Can use public transportation					
Ability to complete meal preparation					
Ability to make purchases and handle money					
Ability to manage money within a budget to meet basic needs					

E. Academics (complete boxes)

	Has skills (yes or no)	Explain to what level
Can identify functional words (i.e., go, stay, stop, etc.)		
Can read		
Knows values of numbers		
Can count		
Can recognize and identify numbers		
Can add and subtract		
Can multiply and divide		

XII. Behavioral Concerns

A. Does the client exhibit "acting out" behaviors?

1. Aggression toward objects? ☐ N/A

In what circumstances	
How often	
How much damage has been done	

2. Aggression toward: ☐ other persons ☐ self ☐ N/A

In what circumstances	
How often	
Has injury occurred	

3. Has this behavior been analyzed by a behavioral specialist? ☐ N/A

Who	
Has a treatment plan (or behavior modification program) been developed?	
If so, describe	

B. Does the client "act out" in a sexual manner? ☐ N/A

Exhibit provocative behavior?	
Exhibit inappropriate behavior toward members of either sex?	
Could the client be easily exploited?	

C. Other Behaviors:

☐ Verbal Aggression ☐ Withdrawn ☐ Disruptive noises
☐ Rebellious/noncompliant ☐ Runs away ☐ Self-injurious behavior
☐ N/A

D. Supervision: Does the Person Need 24/7 Supervision? ☐ Yes ☐ No

How do you meet the 24/7 supervisory needs? _____

_____

_____

If no, how long can the person be left alone: _____

_____

_____

What safety measures are used when person is alone: _____

_____

_____

XIII. Additional Comments

Completed By: _____

Date: _____

AB/
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