

General Information

Full Legal Name _____ Nickname _____

Social Security Number _____ Date of Birth (mo/day/year) ___/___/___ Gender _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Birth Information

Date of Birth (mo/day/yr) ___/___/___ City _____ State _____

Weight _____ Length _____

Obstetrician (name and location) _____

Delivery Hospital _____

Relevant Information About the Delivery _____

Father's Information

Full Legal Name _____

Social Security Number _____ Living? Yes No

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Date of Birth (mo/day/yr) ___/___/___ City _____ State _____ Blood Type _____

Marital Status _____ Name of Spouse _____

Father's Sibling Name/City/Phone _____

Father's Sibling Name/City/Phone _____

Father's Sibling Name/City/Phone _____

Mother's Information

Full Legal Name _____

Social Security Number _____ Living? Yes No

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Date of Birth (mo/day/yr) ___/___/___ City _____ State _____ Blood Type _____

Marital Status _____ Name of Spouse _____

Mother's Sibling Name/City/Phone _____

Mother's Sibling Name/City/Phone _____

Mother's Sibling Name/City/Phone _____

Siblings

Name _____ Age _____ Gender _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Name _____ Age _____ Gender _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Name _____ Age _____ Gender _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Other Relatives and Friends

Name _____ Relationship _____

Address _____

Phone _____ Email Address _____

Name _____ Relationship _____

Address _____

Phone _____ Email Address _____

Name _____ Relationship _____

Address _____

Phone _____ Email Address _____

Medical History and Care

Diagnoses _____

Intellectual Functioning Level _____

(normal, mild disab., moderate disab., severe disab., profound disab., undetermined, etc.)

Speech Functioning Level _____

(normal, mildly impeded, severely impeded, requires speech device, etc.)

Mobility Functioning Level _____

(walks unassisted, cane, crutches, scooter, wheelchair, etc.)

Visual Functioning Level _____

(normal, corrective glasses, contact lenses, requires Braille, legally blind, etc.)

Hearing Functioning Level _____

(normal, mild loss, mod. loss, hearing aid(s), use sign lang., cochlear implants, etc.)

Blood Type/Conditions _____

Immunizations/Date (e.g. Smallpox/2010) _____

Physicians

Name/Specialty _____

Address/Phone _____

Findings/Treatment _____

Name/Specialty _____

Address/Phone _____

Findings/Treatment _____

Name/Specialty _____

Address/Phone _____

Findings/Treatment _____

Name/Specialty _____

Address/Phone _____

Findings/Treatment _____

Dentist/Orthodontist _____

Therapists/Phone/Duration (e.g. Dr. Carol Choi speech/513.700.2144/5 yrs) _____

Diagnostic/Genetic Testing Results _____

Allergies/Physician _____

Surgical Procedures/Date/Location (e.g. Tonsils, 2009, Lansing Gen'l Hosp.) _____

Other Hospitalizations or Inpatient Treatment/Date/Location (e.g. asthma attack, 2007, Christ Hosp. Cincinnati) _____

Orthopedic Conditions _____

Cardiac Conditions _____

Devices to Assist with Daily Living (e.g. shower chair, hand splints, etc.) _____

Prescription Medication(s)/Reason/Dosage _____

Over The Counter Medication(s)/Reason/Dosage _____

Dietary Considerations (food allergies, no sugar, nut allergy, choking hazards, favorite foods, etc.) _____

Incontinence Supplies _____

Birth Control _____

Philosophy on New Treatments or Therapies _____

Government Benefits & Service Programs

Benefit/Program _____

Name of Provider _____ Start Date _____

Benefit Amount/Frequency _____ Still Receiving Benefits?

Benefit/Program _____

Name of Provider _____ Start Date _____

Benefit Amount/Frequency _____ Still Receiving Benefits?

Benefit/Program _____

Name of Provider _____ Start Date _____

Benefit Amount/Frequency _____ Still Receiving Benefits?

Benefit/Program _____

Name of Provider _____ Start Date _____

Benefit Amount/Frequency _____ Still Receiving Benefits?

Living Arrangements

Include any required accommodations or restrictions such as shared room, group home, neighborhood setting, etc.

Past _____

Present _____

Future (1st choice) _____

(2nd choice) _____

Personal Finances (skill level, spending habits, allowance, etc.) _____

Education

Previous Schools/Years _____

Current Schools or Programs _____

Vocational Training Programs/Years _____

Integration experiences _____

Employment

Previous Employment/Work Programs _____

Current Employment/Work Programs _____

Employment Assistance Required (e.g. restricted lifting, wheelchair access, etc.) _____

Personality and Habits

Self Esteem _____

Sleep Habits _____

Unique Personality Traits _____

Adaptability to Change _____

Interaction With Animals _____

Is Upset By _____

Shows Anger By _____

Is Afraid Of _____

Feels Better When _____

Other Unique Behaviors _____

Recreation & Fitness

Previous Programs/Activities _____

Current Programs/Activities _____

Fitness Level and Skills (e.g. can swim, dance, play basketball, etc.) _____

Vacations _____

Favorite TV/Movies _____

Favorite Music _____

Favorite Books _____

Other Favorite Activities (e.g. museum, zoo visits, pizza parlor, etc.) _____

Spirituality & Values

Religion _____ House of Worship Attended _____

Preferred Clergy _____ Type of Participation in Church Activities _____

What Values (religious or otherwise) Should be Emphasized and Reinforced? _____

Volunteering/Community Involvement _____

Legal Guardians

Current Guardian(s) _____

Address _____

Phone _____ Email Address _____

Successor Guardian(s) _____

Address _____

Phone _____ Email Address _____

Special Needs Trust

Trust Name/Date of Trust _____

Trustee Name/Address _____

Trustee Phone/Email _____

Successor Trustee/Phone/Email _____

Power of Attorney – Finances

Appointed to receive and administer Social Security and government benefits, etc.

Name _____ Address _____

Phone _____ Email Address _____

Date Power was Granted (mo/day/yr) ____/____/____ Is Power Durable?

Power of Attorney – Medical

Name _____ Address _____

Phone _____ Email Address _____

Date Power Was Granted (mo/day/yr) ____/____/____ Is Power Durable?

Location of Important Information

Will _____

Trust _____

Insurance Policies

Life _____

Health _____

Accident _____

Homeowners _____

Auto _____

Birth Certificate _____

Marriage Certificate _____

Adoption Papers _____

Military Discharge _____

Tax Records and Returns _____

Bank Accounts/Acct Number (e.g. U.S. Bank/23-987)

Checking _____

Savings _____

Credit Cards/Acct Number _____

Titles

Autos _____ Land _____

Safe Deposit Box _____ Safe Deposit Box Key _____

Other (e.g. power of attorney, Social Security records, etc.) _____

Contacts

Attorney _____ Address _____

City _____ State ____ ZIP _____ Current Phone (____) _____

Accountant _____ Address _____

City _____ State ____ ZIP _____ Current Phone (____) _____

Insurance Agent _____ Address _____

City _____ State ____ ZIP _____ Current Phone (____) _____

Investment Advisor _____ Check here if investment advisor is also insurance agent

Address _____

City _____ State ____ ZIP _____ Current Phone (____) _____

Bank _____ Address _____

City _____ State ____ ZIP _____ Current Phone (____) _____

Bank _____ Address _____

City _____ State ____ ZIP _____ Current Phone (____) _____

Final Arrangements

Funeral/Burial Arrangements Have Been Made Burial Cremation

Funeral Home Name/Phone _____

Cemetery _____

Casket Preference _____

Headstone Preference _____

Epitaph _____

Pastor Preference _____

Pall Bearers _____

Music (specific songs/hymns and/or musicians) _____

Flowers _____

Other Requests (favorite scripture, memorial ideas) _____

Obituary (In summary, what should it say and where would should it be published?) _____
