Tualatin Hills Park & Recreation District Inclusion Intake Form for Adults

This form is specifically for participants who need inclusion assistance services.

Please complete this form and return to:
Attn: Athletic Center
15707 SW Walker Rd. Beaverton, OR 97006
Email: inclusion@thprd.org ▪ Phone: 503-629-6330

NOTICE: Inclusion Services requests that this form be completed quarterly to keep participant information updated. All information will be kept confidential and shared only with those persons assisting the participant. Questions related to disability and diagnoses are optional. Please provide as much information as you are comfortable with sharing. Information will be used to develop an Inclusion Plan to assist with the success of inclusion.

Date: _____

Participant Name: _____ Preferred Name: _____

Birthdate: _____ Age: _____ Gender: ☐ Female ☐ Male ☐ Other: _____

Address: _____ City: _____ Zip Code: _____

Day Phone: _____ Cell Phone: _____ Email: _____

Preferred method of communication: ☐ Email ☐ Day Phone ☐ Cell Phone

Preferred language of communication: ☐ English ☐ Spanish ☐ Other: _____

Guardian/Power of Attorney Name: _____ Relation to Participant: _____

Day Phone: _____ Cell Phone: _____ Email: _____

Preferred Method of Communication: ☐ Email ☐ Cell Phone ☐ Day Phone

Preferred Language of Communication: ☐ English ☐ Spanish ☐ Other: _____

Describe accommodation needed (could include nature of disability):

_____

_____

_____

_____

Section 1: EMERGENCY INFORMATION

In case of emergency, in addition to guardian/power of attorney (if applicable), please contact:
Name: _____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____

Section 2: MEDICAL INFORMATION

Medical conditions? (*diabetes, allergies, seizures, asthma, autism, down syndrome, etc.*) ☐ YES ☐NO
If yes, please specify: _____

Are there any dietary restrictions or food allergies/intolerances? ☐ YES ☐NO
If yes, please specify: _____

Hospitalizations or changes in condition in the last year that we should be aware of? ☐ YES ☐NO
If yes, please specify: _____

Has the participant received Physical Therapy in the last year? ☐ YES ☐NO
If yes, please specify: _____

Is the participant currently on any medications? ☐ YES ☐NO
If yes, please specify: (*Attach additional sheets if needed or attach current MAR*)

Name of Medication	Dosage	AM	Noon	PM	Reason for Taking
EX: "Depakote"	*125 mg = 1 tablet*	*10:00am*	*n/a*	*2:00pm*	*Controls seizures*

*PLEASE NOTE: Staff will not administer medications to participants

MOBILITY

Does the participant walk independently? ☐ YES ☐NO
If no, please specify: _____

Does the participant use an assistive device(s): ☐ YES ☐NO
☐ Wheelchair ☐ Cane ☐ Walker ☐ Other: _____

If assistive devices are used, does the participant use equipment independently? ☐ YES ☐NO

Is the participant able to go from sitting to standing independently? ☐ YES ☐NO

PERSONAL CARE

Please Note: Inclusion Assistants do not provide personal care (including, but not limited to: toileting, dressing, transporting, eating, etc.) for Inclusion Services

VISION/HEARING

☐ Legally blind ☐ Wears glasses ☐ Partial vision ☐ Right vision only ☐ Left vision only
☐ Deaf ☐ Wears hearing aids ☐ Partial hearing ☐ Right hearing only ☐ Left hearing only

COMMUNICATION

Is English the participant's primary language? ☐ YES ☐NO

If no, what is the participant's primary language: _____

Does the participant use verbal language? ☐ YES ☐NO

If no, please indicate form of language:

☐ Communication Board ☐ ASL/Sign Language ☐ Pictures ☐ Other: _____

Are there concerns with the participant's memory? ☐ YES ☐NO

If yes, specify: _____

_____

Concerns with:

☐ Short term memory ☐ Long term memory ☐ Other: _____

Section 3: SAFETY

Does the participant have safety (wandering, falls) concerns? ☐ YES ☐NO

If yes, please explain: _____

_____

_____

Check all that apply:

- ☐ Able to be left alone
- ☐ Poor short term memory
- ☐ Poor long term memory
- ☐ Unable to be left along
- ☐ Easily wanders
- ☐ Impulsive
- ☐ Unknowingly puts self at risk
- ☐ Unable to communicate needs
- ☐ Recognizes danger
- ☐ History of fall(s)
- ☐ History of cardiac event(s)
- ☐ Unsteady balance
- ☐ Unable to pick objects off floor
- ☐ Afraid of falling
- ☐ Verbally aggressive to others
- ☐ Physically aggressive to others
- ☐ Has specific fears/concerns (if checked please list): _____

Section 4: INCLUSION GOALS

What would the participant like to gain from our services?

What things have contributed to the participant having success in the past?

What things have contributed to the participant not having success in the past?

Please describe goals in specific areas provided below.

Balance ☐ YES ☐NO	Strength ☐ YES ☐NO
Range of motion ☐ YES ☐NO	Independence ☐ YES ☐NO
Developing routine ☐ YES ☐NO	Social engagement ☐ YES ☐NO
Other: _____ ☐ YES ☐NO	Other:_____ ☐ YES ☐NO

Is there anything else you would like to share with us?