Wheelnutz Garage appreciates that everyone is unique, please help us to get to know you by answering the following:

Participants accessing our services may nominate a representative or support person of their choice to provide support. Please provide their details below and/or we can provide you a separate form to confirm the nomination. It can also be found on our website www.wheelnutzgarage.com

|  |  |
| --- | --- |
| **Participant Details** | |
| **Participant First Name:** |  |
| **Participant Last Name:** |  |
| **Participant Date of Birth:** |  |
| **NDIS Number:**  **If applicable** |  |
| **NDIS Plan Dates:** |  |
| **NDIS Funding: (please circle)** | Core Capacity SLES |
| **NDIS Funding Type:**  **If applicable** | ☐ Agency Managed (NDIS)  ☐ Self Managed ☐ Plan Managed |
| **Provide Plan Manager (if applicable) see NDIS Funding Type** |  |
| **Address** |  |
| **Contact Number** |  |
| **Email** |  |
| **Preferred method of contact** | ☐ Phone ☐ Mail  ☐ Email ☐ SMS |

|  |  |
| --- | --- |
| **Representative or Emergency Contact Details** | |
| **First Name** |  |
| **Last Name** |  |
| **Relationship to Participant** |  |
| **Address** |  |
| **Phone Number** |  |
| **Email** |  |
| **Preferred method of contact** | ☐ Phone ☐ Email ☐ Mail ☐SMS |

**Why are you here?**

**We want to be sure we support you towards reaching your goals. We also need to ensure that your participant aligns with your NDIS goals.**

**Please provide us your NDIS goals below:**

|  |  |
| --- | --- |
| NDIS Goal 1: |  |
| Funding | NDIS Goal 1 will be funded from Core/Capacity, unless provided further information or a change requested. |
| NDIS Goal 2: |  |
| Funding | NDIS Goal 2 will be funded from Core/Capacity, unless provided further information or a change requested. |

**You may already have strategies in place to help with the above...........**

**Do you have any of the following reports/ assessments/ documents you can share with us?**

* **Latest Functional Capacity Assessment**
* **Latest Psychosocial or Psychologist Report**
* **Latest Physiotherapy Report**
* **Positive Behaviour Support Plan**
* **School Reports or Assessments.**

|  |  |
| --- | --- |
| **About you** | |
| **Living Situation** | ☐ Own home (alone)  ☐ Own Home (with family)  ☐ Supported Accommodation  ☐ Temporary  ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Aboriginal or Torres Strait Islander descent?** | ☐ Yes  ☐ No |
| **Primary Formal Diagnosis** |  |
| **Secondary Formal Diagnosis** |  |
| **Do you have any allergies? If yes please provide below** |  |
| **Please provide all medical diagnoses and medicine that may affect the support provided** |  |

|  |  |
| --- | --- |
| **Communication** | |
| **Type** | ☐ Verbal  ☐ Non-Verbal  ☐ Communication aids required  ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Are you of a culturally or linguistically diverse background?** | ☐ Yes  ☐ No  Details: |
| **Do you have any culture, diversity, values and beliefs of which we should be aware?** | ☐ Yes  ☐ No  Details: |
| **Languages Spoken** | ☐ English  ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Is an Interpreter required?** | ☐ No  ☐ Hearing Impaired  ☐ Language |

|  |  |
| --- | --- |
| **Consent** | |
| **Do you consent to participating in and use of...** | ☐ Photos for Goal Data  ☐ Photos for social media  ☐ Photos for the website  ☐ Participating in audits in respect of our business by the NDIS Commission and its auditors  ☐ Your personal information being recorded in audio and/or visual format  ☐ None of the above |

|  |  |  |
| --- | --- | --- |
| **Dietary Requirements** | | |
| **I have the following allergies/intolerances and my favourite food is...** | | |
| **No dietary requirements** | ☐  **Yes** | ☐  **No** |
| **Vegetarian** | ☐  **Yes** | ☐  **No** |
| **Vegan** | ☐  **Yes** | ☐  **No** |
| **I am allergic to**  **(please list)** |  | |
| **I am unable to eat (sensory/intolerances)** |  | |
| **My favourite food is...** |  | |
| **Adventure Crew can assist me during mealtimes by...** | | |
| ☐ | I can identify what foods are safe for me to eat (if required due to allergy or dietary requirements). | |
| ☐ | If I have a food allergy, I have provided Adventure Crew with a management plan. | |
| ☐ | If required I will bring any medications to assist me with my allergy and have completed the relevant medical forms | |
| ☐ | I prefer to provide my own food and will do so | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Mental Health** | | | |
| I have/experience... | | | |
| ☐ | Depression | ☐ | Anxiety |
| ☐ | Psychosis | ☐ | Schizophrenia |
| ☐ | Bipolar | ☐ | Other |
| I would like Adventure Crew to help me manage this by... | |  | |
| My triggers may include... | |  | |
| ☐ | I have received medical support to assist me and Adventure Crew has a copy of any relevant management plans to help me manage. | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Physical Health** | | | |
| I have... | | | |
| ☐ | Diabetes | ☐ | Sleep Apnoea |
| ☐ | Epilepsy | ☐ | Dietary Needs |
| ☐ | Asthma | ☐ | Blood Disorders |
| ☐ | Visual Impairment | ☐ | Hearing Impairment |
| ☐ | Cognitive Impairment | ☐ | Heart Conditions |
| ☐ | Allergies to: | | |
|
| ☐ | Other: | | |
|
| I am on the following medications: | | List of medications: | |
| I would like Wheelnutz Garage to help me manage this by... | |  | |
| **Please supply Wheelnutz Garage with relevant management plans prior to commencing programs.** | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Practical Support Needs** | | | | |
| Check the boxes which best represent you and your support needs… | | | | |
| **Behaviour** | | I can do independently | I need a little help | I cannot do independently |
| Traffic awareness | | ☐ | ☐ | ☐ |
| Staying with the group | | ☐ | ☐ | ☐ |
| Communicating appropriately | | ☐ | ☐ | ☐ |
| Looking after property | | ☐ | ☐ | ☐ |
| Being aware of personal space | | ☐ | ☐ | ☐ |
| Keeping my hands to myself | | ☐ | ☐ | ☐ |
| Travelling safely in a car | | ☐ | ☐ | ☐ |
| Following instructions | | ☐ | ☐ | ☐ |
| Swimming and safety around water | | ☐ | ☐ | ☐ |
| I can handle my own spending money | | ☐ | ☐ | ☐ |
| I am comfortable in my sleeping routine | | ☐ | ☐ | ☐ |
| Adventure Crew can assist me by… | | | | |
| ☐ | I have provided Wheelnutz Garage with any relevant behaviour plans or Allied Health Assessment for assisting me when required. | | | |

**Health requirements**

|  |  |  |  |
| --- | --- | --- | --- |
| **Activity** | **Tick one** |  | **Outline condition, treatments, aids/assistance required, from whom and when** |
| Continence | ☐ | Continent with regular bowel and bladder action |  |
| ☐ | Constipation, diarrhoea or incontinence (using medication, supplements, pads) |
| ☐ | Medical interventions (catheter, stoma bag) |
| Skin Integrity | ☐ | No skin problems |  |
| ☐ | Some skin problems (rash, skin treatments) |
| ☐ | Pressure areas (currently have, at risk, or had in past) |
| Swallowing | ☐ | No swallowing issues |  |
| ☐ | Some swallowing problems (choking, coughing during normal meal, reduced appetite) |
| ☐ | Major swallowing difficulties (modified diet, feeding tube) |
| Health professionals | ☐ | Have had a GP check up in the last 12 months |  |
| ☐ | See a specialist regularly |
| ☐ | Have a case manager/support coordinator |
| Muscular pain | ☐ | No pain |  |
| ☐ | Moderate pain |
| ☐ | Severe pain |
| Nerve pain | ☐ | No pain |  |
| ☐ | Moderate pain |
| ☐ | Severe pain |
| Falls | ☐ | No falls in past 12 months |  |
| ☐ | Less than 3 falls and no serious injury from a fall in past 12 months |
| ☐ | More than 3 falls or a serious injury from a fall in the past year |
| Muscular issues (other than pain) | ☐ | No problems |  |
| ☐ | Some muscle weakness, tremor, spasms, spasticity or problems with balance |
| ☐ | Serious muscle weakness, tremor, spasticity or problems with balance |
| Other health concerns | ☐ | Fatigue |  |
| ☐ | Visual disturbance |
| ☐ | Temperature intolerance |
| ☐ | Other comorbidities |

**Social Requirements**

|  |  |  |
| --- | --- | --- |
| **Activities** | **Outline how you want to do this activity** | **Provide details of the activity, the time spent, the assistance required, from whom and when (including vouchers)** |
| **Family:** |  |  |
| **Hobbies & Interests:** |  |  |
| **Religion & spirituality** |  |  |
| **Outings:**  E.g. theatre, cafes, exhibitions, drives, group activities |  |  |
| **Computer:**  E.g. games, shopping, education, bookings |  |  |
| **Employment:**  Education, Volunteering |  |  |
| **Sports:** |  |  |
| **Music:**  Likes, dislikes |  |  |
| **Movies/TV:**  Likes, dislikes |  |  |
| **Well-being:**  E.g. exercise, gym, swimming, massage, yoga, meditation etc... |  |  |
| **Food and alcohol:**  Likes, dislikes, diets |  |  |

**Behavioural requirements**

|  |  |  |  |
| --- | --- | --- | --- |
| **Issue** | **Tick one** | **Assistance I need** | **Outline the issue, aids, assistance and management strategies required** |
| Communication | ☐ | No assistance required (including independent use of aids and adaptive technology) |  |
| ☐ | Some assistance required (prompting, assistance with aids) |  |
| ☐ | Assistance always required |  |
| Memory problems Confusion | ☐ | No |  |
| ☐ | Yes |  |
| Concentration problems | ☐ | No |  |
| ☐ | Yes |  |
| Planning problems | ☐ | No |  |
| ☐ | Yes |  |
| Spiritual needs | ☐ | No |  |
| ☐ | Yes |  |
| Mood | ☐ | Mostly positive |  |
| ☐ | Experience sadness, anxiety or emptiness around 50% of time |  |
| ☐ | Feelings of anxiety, sadness or emptiness lasting most of the day, nearly every day |  |
| Decision Making | ☐ | No help needed |  |
| ☐ | Need some help |  |
| ☐ | Not able to make any decisions |  |
| Do you have a will? | ☐ | No |  |
| ☐ | Yes |  |
| Do you have an Enduring Power of Attorney or Guardian? | ☐ | No |  |
| ☐ | Yes |  |
| Do you have an Advanced Care Plan? | ☐ | No |  |
| ☐ | Yes |  |

|  |  |  |
| --- | --- | --- |
| **What things are important for people to understand about you when caring for you?** | **Provide details** | **Outline how you like this to be managed** |
| Who makes the decisions? |  |  |
| What routines do you have? |  |  |
| What makes you happy? |  |  |
| What helps you relax? |  |  |
| What causes you stress? |  |  |
| What makes you frustrated? |  |  |
| What makes you angry? |  |  |

|  |
| --- |
| **Consent** |
| Please sign below to indicate your consent and agreement to the details set out in this Participant intake form above  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Signed** for and on behalf of **Adventure Crew Pty Ltd trading as Wheelnutz Garage** **ABN 19 647 649 607 (Adventure Crew)**, by:  ……………..……………………………..  Signature  ……………..……………………………..  Name (please print)  Signed by the **Client**:  ……………..……………………………..  Signature  ……………..……………………………..  Name (please print)  Signed by the **Representative**:  ……………..……………………………..  Signature  ……………..……………………………..  Name (please print) |