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

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| **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 |

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| **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.**

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| **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** |  |

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

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| **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 |

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| **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 |

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| **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. |

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| **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.** |

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| **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**

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| **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**

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| --- | --- | --- |
| **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**

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| --- | --- | --- | --- |
| **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 |  |

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| --- | --- | --- |
| **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? |  |  |

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| **Consent** |
| Please sign below to indicate your consent and agreement to the details set out in this Participant intake form aboveDate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Signed** for and on behalfof **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)  |