

# ADAPTIVE BEHAVIOR SUMMARY

Consumer Name: \_\_\_\_\_  
 Checklist completed by: \_\_\_\_\_  
 Relationship to consumer: \_\_\_\_\_

Consumer's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Consumer's Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Date Completed: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

## I. MEDICAL INSURANCE & BIRTH INFORMATION

MEDICAID NUMBER #	MEDICARE NUMBER #	PRIVATE CARRIER Name, Policy and Telephone # _____ _____ # ( ) -	
BIRTH HOSPITAL	CITY/STATE	COUNTY (IF IN NJ)	COUNTRY (IF OUTSIDE USA)

## II. PARENT INFORMATION & EMERGENCY CONTACTS

MOTHER	Name	Home Phone	Work Phone
FULL ADDRESS			EMERGENCY CONTACT? <input type="checkbox"/> Yes <input type="checkbox"/> No
DATE OF BIRTH	SOCIAL SECURITY #	MARITAL STATUS/MAIDEN NAME	VETERAN? <input type="checkbox"/> Yes <input type="checkbox"/> No
			MOTHER DECEASED? <input type="checkbox"/> Yes <input type="checkbox"/> No
FATHER	Name	Home Phone	Work Phone
FULL ADDRESS			EMERGENCY CONTACT? <input type="checkbox"/> Yes <input type="checkbox"/> No
DATE OF BIRTH	SOCIAL SECURITY #	MARITAL STATUS	VETERAN? <input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
OTHER RELATION?	NAME	HOME PHONE	WORK PHONE
FULL ADDRESS			EMERGENCY CONTACT? <input type="checkbox"/> Yes <input type="checkbox"/> No
OTHER RELATION?	NAME	HOME PHONE	WORK PHONE
FULL ADDRESS			EMERGENCY CONTACT? <input type="checkbox"/> Yes <input type="checkbox"/> No

### OTHER SOURCES OF INFORMATION

In order to make a decision on eligibility or to properly serve the applicant after eligibility is established, more information must sometimes be obtained. Please list the names and addresses of other sources of information (such as school programs, child study teams, or other agencies) who have records relating to the applicant's disability that you feel we should know about.

NAME/CONTACT PERSON	ADDRESS	CITY / STATE	TELEPHONE	WHEN INVOLVED?
				<input type="checkbox"/> PAST <input type="checkbox"/> Current
				<input type="checkbox"/> PAST <input type="checkbox"/> Current
				<input type="checkbox"/> PAST <input type="checkbox"/> Current

**V. ADDITIONAL COMMENTS**

Is there other information you have not listed that you feel we should know about this person? Please attach additional sheet of paper if necessary. Thank you for your assistance.

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**V. COMMUNICATION SKILLS**

1. Please list the languages used by this person: \_\_\_\_\_

2. Understands the spoken word?  YES  No

3. Follows simple directions?  YES  No

4. Any hearing problems?  YES  No

5. Communications through:  YES  No

a) Verbal speech  YES  No

b) Communication device  YES  No

c) Gestures  YES  No

d) Signs  YES  No

Gestures and signs known and used: \_\_\_\_\_

6. Dials and speaks over the telephone?  YES  No

7. Can this person read?  YES  No

8. Can this person write?  YES  No

**VI. SOCIAL BEHAVIORS**

9. What does this person enjoy doing? \_\_\_\_\_

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10. How are emotions such as anger or frustration displayed? \_\_\_\_\_

11. Is this person sexually active?  YES  No      Comments: \_\_\_\_\_

12. How are symptoms of illness communicated? \_\_\_\_\_

13. Does this person smoke?  YES  No      Comments: \_\_\_\_\_

14. Are there any unusual fears? (list): \_\_\_\_\_

15. Does this person

a) Wander off if not closely supervised?  YES  No

b) Run away?  YES  No

c) Have any unusual sleep patterns?  YES  No

(Describe) \_\_\_\_\_

16. Can this person be in a home with children?  Yes  No

17. Is this person

a) Self-abusive?  Yes  No If yes, how? \_\_\_\_\_

b) Abusive to others?  Yes  No If yes, how? \_\_\_\_\_

c) Destructive to property?  Yes  No If yes, how? \_\_\_\_\_

**COMMUNITY AWARENESS**

18. Does this person attend a Day Program?  Yes  No If yes, give program name, address and contact: \_\_\_\_\_

19. What community activities are enjoyed? \_\_\_\_\_

20. Does the person demonstrate appropriate behavior during these activities?  Yes  No If no, comment: \_\_\_\_\_

21. Is this person aware of ordinary household dangers, such as stairs, heaters, electric outlets, household cleaners, ovens, wood burning stoves and fireplaces?  Yes  No  No opportunity to observe If no, specify \_\_\_\_\_

22. Does this person demonstrate awareness of community dangers, including traffic, being overly friendly with strangers,  Yes  No  No opportunity to observe If no, specify: \_\_\_\_\_

23. Can the consumer count change / make purchases?  Yes  No  Only under supervision

24. Can this person tell time?  Yes  No  to the hour  to the half-hour  to quarter-hour

**SELF - HELP SKILLS** (check appropriate boxes)

**TOILETING**

25. Does this person wear diapers/continency garments?  Yes  No If yes, when  Day  Night  
(if continency garments are worn, please skip to section B. Hygiene).

26. Appropriate toilet habits?  Yes  No If no, specify \_\_\_\_\_

27. Any bladder accidents?  Yes  No If yes, Day  Night  (how often? \_\_\_\_\_)

28. Any bowel accidents?  Yes  No If yes, Day  Night  (how often? \_\_\_\_\_)

29. Toilets self independently?  Yes  No If No, what kind of help is needed? \_\_\_\_\_

30. Wipes self with toilet paper?  Yes  No  Only if reminded  Only if verbally directed  Only with physical assistance

31. Washes hands after toileting?  Yes  No  Only if reminded  Only if verbally directed  Only with physical assistance

32. Takes care of menstrual Needs Independently?  Yes  No  Only if reminded  Only if verbally directed  Only with physical assistance

**B. HYGIENE**

INDEPENDENT  
NEEDS TO BE REMINDED  
NEEDS VERBAL DIRECTION  
NEEDS PHYSICAL ASSISTANCE  
NO OPPORTUNITY TO OBSERVE

**COMMENTS**

33. Washes and Bathing					
a) Washes and dries hands					
b) Washes and dries face					
c) Bathes self in bathtub					
d) Showers self					
e) Turns on and regulates water temperature					
f) Washes hair					
g) Dries self					
34. Uses deodorant					
35. Combs / brushes hair					
36. Tooth and mouth care					
a) Brushes own teeth					
b) Puts toothpaste on brush					
37. Dentures					
a) Worn regularly					
b) Cares for own dentures					
38. Blows and wipes own nose with tissue					
39. Shaving (usually uses) <input type="checkbox"/> Safely razor <input type="checkbox"/> Electric razor					

**C. DRESSING SKILLS**

40. Undresses self					
41. Buttons					
42. Snaps					
43. Zippers					
44. Fastens a buckle					
45. (Women) hooks own bra					
46. Ties shoes)					
47. Dresses self completely					
48. Changes clothing regularly					
49. Matches colors/patterns					
50. Selects seasonal clothing					

**D. EATING**

51. Feeds self with spoon					
52. Feeds self with fork					
53. Cuts food with a knife					
54. Eats with fingers					
55. Drinks from cup or glass					
56. Any favorite foods? _____					

Consumer Name: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Checklist completed by: \_\_\_\_\_

Phone No.: \_\_\_\_\_

**PHYSICAL CONDITIONS, LIMITATIONS, AND ASSISTIVE DEVICES**

57. Are G-tube feedings given?  Yes  No

58. Is any adaptive feeding equipment used?  Yes  No

If yes, Specify: \_\_\_\_\_

\_\_\_\_\_

59. Is this person on a special diet?  Yes  No

If yes, What kind? \_\_\_\_\_ Low Salt \_\_\_\_\_ Low Sugar \_\_\_\_\_ Low Cholesterol \_\_\_\_\_ Chopped Food  
\_\_\_\_\_ Pureed Food \_\_\_\_\_ Other \_\_\_\_\_

60. If any foods must be avoided because of allergies, digestive problems, religious consideration, or dislike, please list: \_\_\_\_\_

\_\_\_\_\_

61. Please check all the medical problems or related conditions that you are aware of:

	<u>Current</u>	<u>History of Problem</u>
a) Asthma	_____	_____
b) Diabetes	_____	_____
c) Frequent Colds	_____	_____
d) Pneumonia	_____	_____
e) Lung/Breathing Problems	_____	_____
f) Seasonal Allergies/Other	_____	_____
g) Ear Infections	_____	_____
h) Frequent Headaches	_____	_____
i) Serious Skin Problems	_____	_____
j) Gum Problems	_____	_____
k) Dental Problems	_____	_____
l) Hypertension	_____	_____
m) Heart/Circulatory Problems	_____	_____
n) Stomach/Digestive Problems	_____	_____
o) Kidney/Urinary Problems	_____	_____
p) Pica (eats inedible objects)	_____	_____
q) Hepatitis B. Carrier	_____	_____
r) Seizure Disorder	_____	_____

(check type which affects consumer):

\_\_\_\_\_ Loss of consciousness / Grand Mal / Tonic-Clonic

\_\_\_\_\_ Absence, or staring episodes / Petit Mal

\_\_\_\_\_ Tremors

\_\_\_\_\_ Frequency and duration \_\_\_\_\_

s) Other medical problems (List): \_\_\_\_\_

62. Is this person visually impaired?  Yes : \_\_\_\_\_  No

63. Check which of the following best describes mobility:

- Walk independently, with or without physical aids.
- Primarily uses a wheelchair but can move and transfer in and out of it independently.
- Can move the wheelchair independently but needs assistance with transfers.
- Non-Mobile, totally dependent.

64. Height: \_\_\_\_\_ Weight: \_\_\_\_\_

65. Please indicate which of the following the person owns and uses:

- |   |   |
|---|---|
| <input type="checkbox"/> Manual wheelchair    | <input type="checkbox"/> Eyeglasses               |
| <input type="checkbox"/> Motorized wheelchair | <input type="checkbox"/> Hearing aid              |
| <input type="checkbox"/> Stroller             | <input type="checkbox"/> Helmet                   |
| <input type="checkbox"/> Walker               | <input type="checkbox"/> Scoliosis jacket         |
| <input type="checkbox"/> Crutches             | <input type="checkbox"/> Elastic stockings        |
| <input type="checkbox"/> Cane                 | <input type="checkbox"/> Braces (AFO, KAFO, etc.) |
| <input type="checkbox"/> Corrective shoes     | <input type="checkbox"/> Dental appliances        |
| <input type="checkbox"/> Car seat             | <input type="checkbox"/> Other: (list)            |

66. Please list all medications taken on a regular basis:

MEDICATION	DOSAGE/TIMES TAKEN	TO CONTROL	PHYSICIAN

67. Method of administering medications (described how independent the consumer is in administering own medications):

68. Allergies to any medications and or other substances?  Yes  No Specify: \_\_\_\_\_

**CURRENT PHYSICIANS**

PHYSICIAN TYPE	NAME	ADDRESS	TELEPHONE
Primary			