

A NEW LEAF, INC.
Adult DT Participant Profile



ISP Start Date: _____ 6-month: _____ End Date: _____

Contact Information:

Participant Last Name: _____			First: _____			M: _____		
Participant birth date: ____/____/____			Nickname: _____			M: ____ F: ____ Age: _____		
Address: _____			City: _____			Zip: _____		
Home Ph#: _____			Cell#: _____			Alt#: _____		
Emergency Contact#: _____			Name/Relation to Participant: _____					
SSN: ____-____-____			Medicaid#: _____			Healthy Connections#: _____		
Whom does the participant reside with? _____								
Marital Status (please circle): Single Married								
Parent/Legal Guardian: _____			Parent: _____					
Address (if diff. from participant) _____								
Name of Parent: _____			Ph# _____			Cell# _____		
Name of Parent: _____			Ph# _____			Cell# _____		

Medical Information:

Primary Physician: _____			Ph# _____			Fax# _____		
Address: _____			City: _____			Zip: _____		
Specialist: _____			Ph# _____			Fax# _____		
Address: _____			City: _____			Zip: _____		
Specialist: _____			Ph# _____			Fax# _____		
Address: _____			City: _____			Zip: _____		
Dietary Considerations: _____								
Known Drug/Food Allergies: _____			Seizures: _____			Frequency _____		
Primary Diagnosis: _____			Secondary Diagnosis: _____					
Required assistive devices: _____								
Other Pertinent Information: _____								
Dentist: _____			Ph# _____			Orthodontist (please circle): Y/N		
Optometrist: _____			Ph# _____					

PA's: 97537 _____ H2032 _____ Other _____

Previous Agency Information:

Development Disability Agency (DDA): _____
Agency Ph# _____ Fax# _____ Administrator: _____
Developmental Specialist: _____ currently receiving: **IB** or **DT** (circle)
Current Related Services: _____
Re-determination Date: _____ IBI/DT Name _____
Do you prefer male or female therapist? _____
Name of Service Coordinator: _____ Agency: _____

School Information:

School Setting: _____ Grade: _____
Name of School(s): _____ / _____
Person to Contact: _____ Alt: _____
Is Participant currently on an IEP or 504 Plan? _____ Case Manager: _____
Is participant receiving services from any of the following: Resource Room, Extended Resource Room, Special Ed. Paraprofessional, or One-on-One Aide? _____
Is the Participant currently using any assistive technology to aide in learning? _____

Additional Information:

Names & Ages of Siblings: _____
Does Participant have any pets? _____
Favorite Likes: _____
Dislikes: _____
Is Participant Sensory sensitive? If yes, please describe (clothing tags, fire alarms, food textures, touch, etc.) _____

