Initial Intake Form

What prompted you to contact us? ___________________________

DATE of Intake: ______________ Intake by: _________________________

NAME:

ADDRESS:

EMERGENCY CONTACT:

PHONE:

1. **Date of birth**
2. **What are the last 4 digits of your SSN? XXX-XX-**
3. **Are you a veteran?**
4. **What is the cause/diagnosis of your vision loss?**
5. **Has your doctor declared you legally blind?**
   a. **Who is your Ophthalmologist?**
6. **Do you live alone?**
7. **What is your current means of transportation?**
8. **Are you currently or have you ever been a client of the State Department of Rehabilitation?**

   a. **Are you currently employed, or looking for employment?**
      i. **If looking, what work experience/skills do you already have?**

b. **Training needs:**
   i. **Are you interested in receiving training to help you stay independent within your home while cooking, cleaning, or organizing? ILS (describe ILS needs) –**

   ii. **Are you interested in receiving training to help you feel confident and safe while walking or taking public transportation? (describe O&M needs) –**

   iii. **Do you need support and/or assistance in adjusting to your sight loss?**

   iv. **Do you currently use a computer, cell phone or tablet?**

   v. **Are you interested in learning adaptive technologies to help you stay connected to your work and personal interests?**

   vi. **Do you want to learn about specialized vision aids?**

c. **Do you have any health conditions or scheduling conflicts that will interfere with your ability to commit to training service appointments?**

d. **May we refer to the appropriate service agency, such as the Department of Rehabilitation or the Veterans Administration?**

e. **Additional Information:**