**C L I E N T I N TA K E F O R M**

**PERSONAL INFORMATION:**

|  |  |
| --- | --- |
| Client’s Full Name: |  |
| Date of Birth: | Gender: |
| Address: |  |
| Contact Number: | Email Address: |
| Emergency Contact Name: | Relationship to Client: |
| Contact Number: | Email Address: |
| NDIS Participant Number: |  |
| NDIS Plan Start Dates: \_\_\_\_\_\_\_\_ NDIS Plan End \_\_\_\_\_\_\_\_\_\_\_\_\_  NDIS Managed funding and contacts:  Self: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NDIA:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| NDIS Plan Category:   * Assistance with social, economic and community participation * Find and Keep a Job * Household tasks * Assistance with Daily care and Life Skills * STA and assistance (Including the provision of respite care) * Accommodation assistance or tenancy assistance * Assistance to access and maintain employment or higher education * Daily Personal activities |  |
| **MEDICAL INFORMATION:** |  |
| Primary Diagnosis or Disability: |  |
| Secondary Diagnoses or Disabilities (if applicable): |  |
| Medications (if any): |  |
| Allergies (if any): |  |
| Medical Conditions or Relevant Health History: |  |
| **SUPPORT REQUIREMENTS:** |  |

Briefly describe the support services required (e.g., personal care, community access, daily living skills, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client NDIS Goals (as per NDIS Plan):

1.

2.

3.

**CONSENT:**

By signing below, I/Participant representative/Support Coordinator acknowledge that the information provided is accurate and complete to the best of my knowledge. I give permission for True Empathy support to access and use this information to provide support services as required under the NDIS plan.

Client / Representative Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: