



Data Collection for Therap Individual Data Form

Identification Data

First Name \* ..... Time Zone .....
Last Name ..... ID Number \* .....
Middle Name ..... Additional ID Type .....
Goes By ..... Additional ID Number .....
ID Type \* ..... Admission Date .....
Birth Date \* .....

Photo

Photo1 [ ] Attached Photo1 Date .....
Photo2 [ ] Attached Photo2 Date .....

Program & Site

[More Programs & Sites can be added in the Therap System]

Table with 3 columns: Program Name, Site Name, Enrollment Date. Multiple rows of dotted lines for data entry.

Residence Address

Residential Program / Site .....
Street 1 \* ..... Street 2 .....
City \* ..... County .....
State \* ..... Zip Code \* .....
Phone \* .....

Birth Place

City ..... State .....
Country [ ] USA [ ] Canada [ ] Other .....

Specifications

Social Security Number ..... Format: xxx-xx-xxxx or xxxxxxxxx
Citizenship \* [ ] USA [ ] Other .....

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Note:- Required fields are marked with an asterisk (\*)



Gender \*  Male  Female

Hispanic ?  Yes  No

Marital Status  Divorced  Married  Separated  Single  Widowed  Unknown

Race  White  American Indian/Alaskan Native  Native Hawaiian/Other Pacific Islander  Asian  Black/African American  Other .....

Hair Color  Black  Blonde  Brown  Gray  Red  White  Brown-light  Brunette  Brown-dark  Other .....

Weight Range From ..... lbs To ..... lbs

Height ..... Feet ..... Inch

Eye Color  Black  Blue  Brown  Gray  Green  Hazel  Other .....

Characteristics .....  
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Communication Modality \*  Verbal  Partially Verbal  Non-verbal  Sign  Communication Device  Other .....

Communication Comments .....  
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Language \*  English  Bengali  Arabic  Creole  Spanish  Polish  Portuguese  French  German  Japanese  Korean  Chinese(Mandarin)  Vietnamese  Russian  Other .....

Religion  Buddhist  Hindu  Jewish  Muslim  Protestant  Greek Orthodox  Catholic  Baptist  Lutheran  Methodist  Episcopal  Presbyterian  Nazarene  Mormon  Church of Latter Day Saints  Seventh Day Adventist  Other .....

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- Religion**     Buddhist     Hindu     Jewish     Muslim     Protestant     Greek Orthodox  
 Catholic     Baptist     Lutheran     Methodist     Episcopal     Presbyterian  
 Nazarene     Mormon     Church of Latter Day Saints     Seventh Day Adventist  
 Other .....

- Mealtime Status**     Eats Independently (with or without adaptive equipment)     Requires Positioning Equipment  
 Requires Support to Eat     Requires Physical Assistance/Equipment

**Dietary Guidelines** .....

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- Food Texture**     Food eaten at normal consistency     Food consistency altered-Chopped  
 Food consistency altered-Ground     Food consistency altered-Puree  
 Food consistency altered-Uses Thickener

**Feeding Guidelines** .....

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- Mobility \***     Walks on own     Walks with assistance     Uses a cane     Uses walker  
 Other .....

**Mobility Comments** .....

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- Supervision \***     No supervision     Supervision for personal care     Line of Sight     Arm's Length  
 Assistance for everything     Assistance for personal care     Never unattended  
 Other .....

**Supervision Comments** .....

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Referral Source .....

Developmental Disability:  Autism  Cerebral Palsy  Epilepsy  Neurological Impairment  Other

Mental Retardation  Mild  Moderate  Profound  Severe  Unspecified

Toileting Status  Toilets Independently  Requires Physical Assistance/Equipment  Scheduled Bladder Program  Scheduled Bowel Program  Requires Prompts/Monitoring  Incontinent/Requires Disposable Briefs

Bathing Status  Independent  Requires Support to Bath/Shower  Independent with Devices

**Contacts**

Guardian of Self

[More Contacts and details can be added in the Therap System]

Name .....

Address .....

Same As Residence Address

Phone Primary .....

Secondary .....

Same as Residence Phone

Relationship To Individual  Parent  Spouse  Relative  Guardian  Advocate  Employer  Payee  Case Worker  Day Program  Other .....

Guardian Type  Plenary  Advocate  Limited  Conservator  Ad Litem  Other .....

Medical Guardian  Yes  No Agency .....

Emergency Contact  Yes  No

**Medical**

**Medical Diagnosis**

Medical Diagnosis Comments .....

Emergency Orders .....

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Allergies \*

Yes  No

If Yes \*

Adaptive Level

Mild

Moderate

Profound

Severe

No Level Indicated

Adaptive Equipment

**Physician**

Title .....

First Name \* ..... Last Name \* ..... Middle name .....

Specialty \* .....

Street 1 \* ..... Street 2 .....

City \* ..... State \* ..... Zip Code \* .....

County ..... Phone \* ..... Fax .....

**Dentist**

Title .....

First Name ..... Last Name ..... Middle name .....

Street 1 ..... Street 2 .....

City ..... State ..... Zip Code .....

County ..... Phone ..... Fax .....

**Hospital**

Name .....

Street 1 ..... Street 2 .....

City ..... State ..... Zip Code .....

County ..... Phone ..... Fax .....

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**Pharmacy**

Name .....  
Street 1 ..... Street 2 .....  
City ..... State ..... Zip Code .....  
County ..... Phone ..... Fax .....

**Insurance**

Medicaid Number ..... Medicare Number .....  
Medicare Effective Date ..... Medicare Section  A  B  Both

**Medicare**

Med Plan D Id ..... Med Plan D Name .....  
Med Plan D Issuer ..... Med Plan D RxBIN .....  
Med Plan D RxPCN ..... Med Plan D RxGRP .....  
Other Benefits .....

**Other Insurance**

Insurance Company ..... Insurance Group .....  
Insurance Policy Number ..... Insurance Policy Holder .....

**Behavior**

Behavior Management .....  
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