LIFTING ADULTS
WITH GUIDANCE

Full name:

Nickname:

Home address:

Home phone / Mobile:

Email address:

Emergency Contact

In case of emergency contact:

Emergency contact's address:

Emergency contact's phone:

Support Coordinator:

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Doctor's name:

Doctor's Phone:

Doctor's address:

Primary Insurance Carrier:

Ins -- Member / Group:

Known allergies:

Diagnosis:

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Name: Date of Birth:

Support Coordinator: Contact Information:

Support Coordination Agency: Contact Information:

Services Requested: (What would you like us to help you with?)

DAY PROGRAM Circle Days you wish to participate in Day Program: (M T W Th F)

If you could choose to be an animal, what would you be and why?

What are your favorite activities to do?

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What do you want to accomplish or learn at our program?

If you could have 3 wishes, what would they be?

1.

2.

3.