Consumer Intake

Name _____ Date of Birth: _____ Age: _____

Address: _____ Social Security #_____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Primary e-Mail: _____

Parent/ Guardian Names: _____

Easterseals Nevada service(s) requested: _____

Primary disability: _____

Medications: _____

Allergies: _____

Services currently being provided by:

[ ] VOC Rehab (BVR) Counselor: _____

[ ] Desert Regional Center (DRC) Service Coordinator: _____

[ ] School District School: _____ Teacher: _____

[ ] Other Case Worker: _____

Guardianship status:

[ ] Self

[ ] Family Member **Name:** _____

[ ] Public Guardian **Name:** _____

Low to moderate income [ ] Yes [ ] No Female head of household [ ] Yes [ ] No

Ethnicity [ ] White [ ] Native American

[ ] Black [ ] Pacific Islander/Alaskan Native

[ ] Hispanic [ ] Other

Emergency Contact:

Name: _____ Relationship to consumer: _____

Home Phone: _____ Work Phone: _____

Name of person completing this form, if other than Easterseals Nevada representative:

_____

The above information is true and correct to the best of my knowledge.

_____ _____

CONSUMER, PARENT, OR GUARDIAN DATE EASTERSEALS NEVADA REPRESENTATIVE DATE

For Office use only. Referring Agency _____ Consumer ID # _____ Case # _____