Please continue notes in the space below if required

____

____

____

HARROGATE Skills 4 Living

CLIENT SUPPORT NEEDS QUESTIONNAIRE

Name:……………………………………………………………………………………..

Please tell us what we need to know about you in order to best support you while using our day service.

Learning difficulties and disabilities

Do you consider yourself to have a learning difficulty and/or disability and/or health condition? Yes ☐ No ☐
If yes, please tick all that apply from the options below:

	Visual Impairment		Severe learning difficulty		Speech, language and communication needs
	Hearing Impairment		Dyslexia		Other physical disability
	Disability affecting mobility		Dyscalculia		Other specific learning difficulty (e.g. Dyspraxia)
	Profound complex disabilities		Autism spectrum condition		Other medical condition (e.g. epilepsy, asthma, diabetes)
	Social and emotional difficulties		Asperger's syndrome		Other learning difficulty
	Mental Health difficulty		Temporary disability after illness/accident		Other disability
	Moderate learning Difficulty		Down's syndrome		Prefer not to say

Health

Do you have any allergies? Yes ☐ No ☐ *(if yes please give details below)*

____

Do you have seizures? Yes ☐ No ☐ *(if yes please give details below)*

____

Are you taking any medication? Yes ☐ No ☐
(if yes please give details of the medication and reasons for taking it below)

____

Do you have any dietary restrictions? Yes ☐ No ☐ *(if yes please give details below)*

____

____

____

Do you have any other health needs that we should be aware of? Yes ☐ No ☐ *(if yes please give details below)*

____

____

____

Behaviour

Do you have any triggers for challenging behaviour? Yes ☐ No ☐ *(if yes please give details below)*

____

____

____

What de-escalating strategies help you stay calm and/or diffuse the situation?

____

____

____

Communication

What is your preferred communication (verbal Makaton, Braille, etc)?

____

____

Do you have any communication support needs? Yes ☐ No ☐ *(if yes please give details below)*

____

____

____

Support needs

Do you require any assistance with routine functions (i.e. going to the toilet, mobility, doing certain activities)?
Yes ☐ No ☐ *(if yes please give details below)*

____

____

____

____

____

____

Risk assessment

Do you have a risk assessment? Yes ☐ No ☐
If yes are you willing to share it with us? Yes ☐ No ☐

Wellbeing

Do you have any fears/phobias or dislikes that we should know about? Yes ☐ No ☐ *(if yes please give details below)*

____

____

____

Further information

If there is any other information you think we may need to know please write details below:

____

____

____

____

____

____

____

Please continue on the back page if additional space is needed.

Signatory details

Name: ____ **Date:** ________________

Signature:

Please tick one of the following:

☐ I am the client
☐ I am the client's Carer/Parent
☐ I am the client's Care Manager
☐ I am the client's Key worker
☐ I am the client's Residential Care Provider

FOR OFFICE USE ONLY:

Harrogate Skills 4 Living
Receiving Officer Signature:...Date of Agreement:.............................

01423 593719 | skills@hs4lc.org.uk | hs4lc.org.uk
No.9 North Park Road, Harrogate HG1 5PD