

**Please continue notes in the space below if required**

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)

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

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## Behaviour

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

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

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## Communication

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

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

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## 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)

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## Risk assessment

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

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## Wellbeing

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

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## Further information

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

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

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## Signatory details

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature:



Please tick one of the following:

<input type="checkbox"/> I am the client	<input type="checkbox"/> I am the client's Carer/Parent
<input type="checkbox"/> I am the client's Care Manager	<input type="checkbox"/> I am the client's Key worker
<input type="checkbox"/> I am the client's Residential Care Provider	

### FOR OFFICE USE ONLY:

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