

All About Me

YOUR NAME



ADULT

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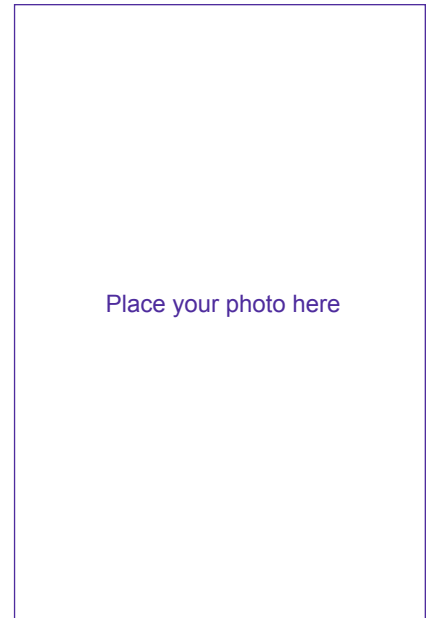
This is Me

My name is: _____

My address is: _____

My phone number is: _____

My birthday is on: _____



What I do during the week day:

What I do in the evening:

What I do on the weekend:

My **favourite people and things** are (for example, friends, pets, books, etc.):



My **favourite places** are (for example, home, park, restaurants, coffee shops):



This is My Family & Friends

These are the names of all the people who live in my home:

_____	_____
_____	_____
_____	_____
_____	_____

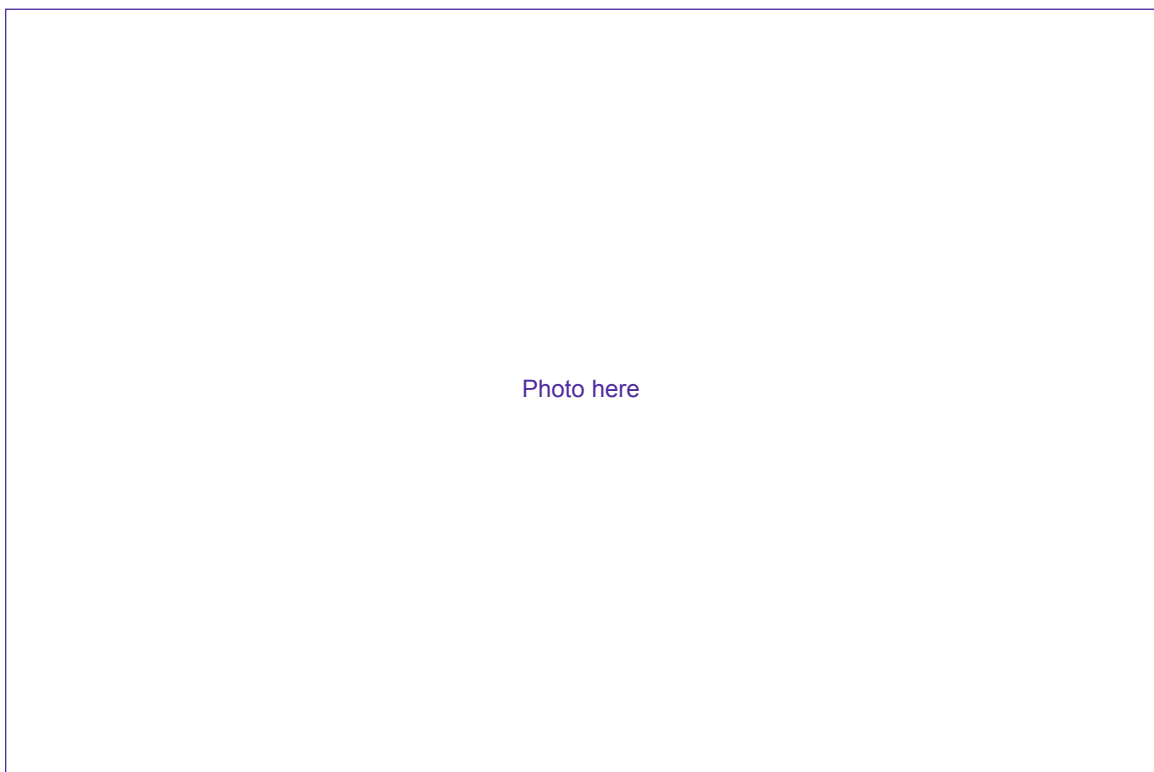


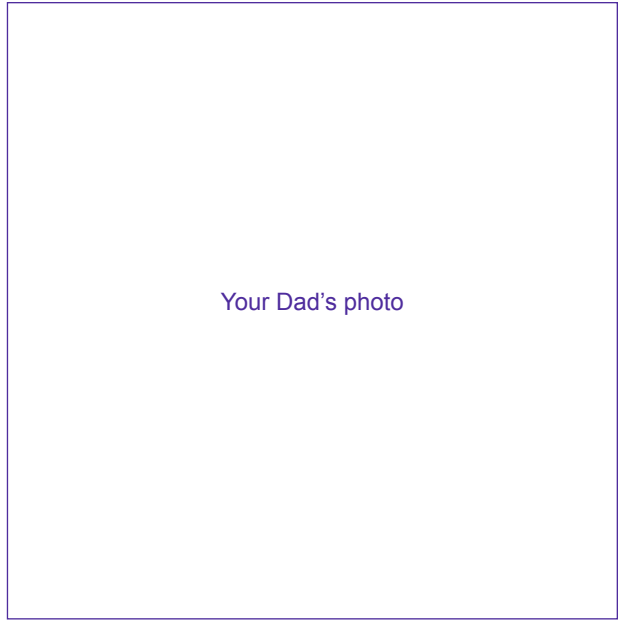
Photo here

People in the photo

_____	_____
_____	_____
_____	_____



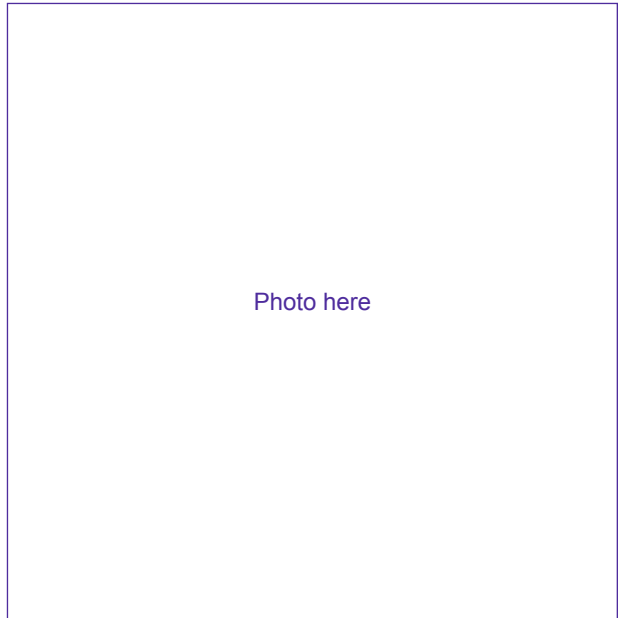
My Mom's name is:



My Dad's name is:

I have ___ brother(s) and these are their names:

I have ___ sister(s) and these are their names:



People in photo:



The **important people** in my life are:

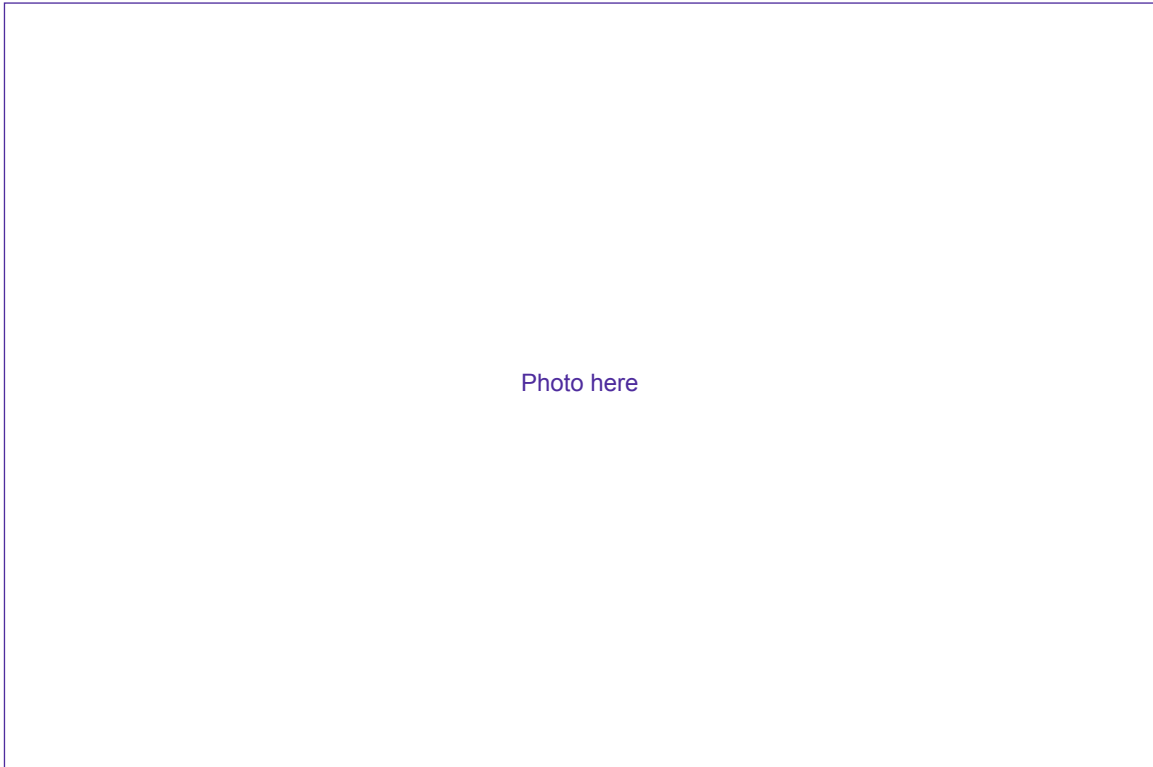


Photo here

People in the photo

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Emergency & Medical Contacts

Emergency Contact #1:

Name: _____ Relationship: _____



Home: _____

Work: _____

Cell: _____

Emergency Contact #2:

Name: _____ Relationship: _____



Home: _____

Work: _____

Cell: _____

Emergency Contact #3:

Name: _____ Relationship: _____



Home: _____

Work: _____

Cell: _____

Parents/Guardians/Caregivers:

Name: _____ Home: _____

Work: _____

Cell: _____

Name: _____ Home: _____

Work: _____

Cell: _____



Health Card #: _____

FAMILY DOCTOR



Name: _____

Phone Number: _____

FAMILY DENTIST



Name: _____

Phone Number: _____

SPECIALISTS



Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

PHARMACY



Name: _____

Phone Number: _____

911 service **is** **is not** available in my area

If not, please list:



Preferred Hospital: _____

Phone: _____

Address: _____

Other Emergency Numbers (If applicable)

Ambulance: _____

Poison Control Centre: _____

Police: _____

Fire: _____

Other Agencies I am Involved With:

Agency

Contact Person

Phone #:

_____	_____	_____
_____	_____	_____
_____	_____	_____

My Medical Information

My _____ tells me that my diagnosis is _____
(parent/doctor)

Medications:

1. Name of Medication: _____ Dosage: _____

When it should be taken: _____ Reason I take it: _____

2. Name of Medication: _____ Dosage: _____

When it should be taken: _____ Reason I take it: _____

3. Name of Medication: _____ Dosage: _____

When it should be taken: _____ Reason I take it: _____

4. Name of Medication: _____ Dosage: _____

When it should be taken: _____ Reason I take it: _____

I require support in taking my medication: Yes No

My medication is usually taken by _____

I prefer my medication to be _____

(crushed, with juice, etc.)

Special instructions/ precautions for giving medication to me:

I am allergic to: _____
(medication, food, environmental)

Please explain: _____

Date of my last doctor's appointment: _____

My immunizations are up to date: Yes No

My Vision: _____

My Hearing: _____

My Mobility: _____

My Respiratory: _____

My Skin Care: _____

I experience seizures: Yes (explained below) No

Details about my seizures (triggers, frequency, etc.):

Absence (Petit Mal): _____

Tonic-Clonic (Grand Mal): _____

Complex-Partial (Psycho Motor): _____

The support I require during and following a seizure is: _____

Other medical information you should know about me:

(conditions, contagious diseases, equipment, supplies, support needs)

Communication

I communicate:

Method	always	sometimes	never	Comments
by using words:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
by using signs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
by using bliss/PECS:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
by using gestures/ facial expressions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

More information about how I communicate: _____

If I need or want something, I will let you know by: _____

My special words, signs, gestures are: _____

When you are communicating with me, I need you to:

Method	always	sometimes	never	Comments
Make eye contact:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use smaller sentences:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Control your tone of voice:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use gestures/ facial expressions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use signs/PECS/bliss:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other information about Me

I Like to Eat

Things that I can make or get for myself are: (i.e., coffee, tea, cereal and meals):

I need assistance to prepare:



Time: _____

Breakfast Foods: _____



Time: _____

Lunch Foods: _____



Time: _____

Dinner Foods: _____

Snacks: Times: _____ Types: _____

I need assistance to eat: Yes No

You can help me eat by: _____

I need special equipment to eat: Yes No

Details: _____

Some foods I eat require special preparation. (i.e. mashed, pureed, cut up finely)

Length of time it takes me to eat: _____

I (am) (am not) prone to choking spells.

Foods I should not eat and why: _____

BEVERAGES I LIKE: (I need to use a straw: Yes No)

- | | | | |
|--------------------------------------|--------------------------------|--|---|
| <input type="checkbox"/> Milk | <input type="checkbox"/> Juice | <input type="checkbox"/> Coffee | <input type="checkbox"/> Chocolate Milk |
| <input type="checkbox"/> Pop | <input type="checkbox"/> Tea | <input type="checkbox"/> Hot Chocolate | <input type="checkbox"/> Water |
| <input type="checkbox"/> Other _____ | | | |

SNACKS I ENJOY:

- | | | | |
|---------------------------------------|-----------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Potato Chips | <input type="checkbox"/> Raisins | <input type="checkbox"/> Ice Cream | <input type="checkbox"/> Yogourt |
| <input type="checkbox"/> Cookies | <input type="checkbox"/> Nuts | <input type="checkbox"/> Pudding | <input type="checkbox"/> Fruit |
| <input type="checkbox"/> Candy | <input type="checkbox"/> Crackers | <input type="checkbox"/> Jello | <input type="checkbox"/> Gum |
| <input type="checkbox"/> Cereal | <input type="checkbox"/> Cheese | <input type="checkbox"/> Apple Sauce | <input type="checkbox"/> Chocolate |

Other _____

Bedtime



I usually go to bed at _____, and I usually wake up at _____ in the morning.

I _____ wake up at night.

always / sometimes / almost never / never

If I do wake up it is usually for _____

I (require) (do not require) assistance during the night.

When I do require assistance it will be for _____

I (need) (do not need) repositioning during the night.

I sleep in a (bed) (bed with rails) .

I like to have my bedroom door _____ and the light _____.

open / shut

on / off

Other helpful things to know, (number of blankets, pillow, nightlight, radio, etc):

My Daily Life

When I'm getting dressed, I can do everything on my own: Yes No

You can help me by: _____

When I need to go to the bathroom I will:

Go by myself: Yes No

Let you know by: _____

Need your assistance with: _____

I wear: Underwear Briefs

And extras can be found: _____

When it comes to personal hygiene, I am totally independent: Yes No

I need some help:

Bathing: Yes No Comments: _____

Washing hands and face: Yes No Comments: _____

Brushing teeth: Yes No Comments: _____

Combing/Brushing hair: Yes No Comments: _____

Feminine Hygiene: Yes No Comments: _____

Shaving: Yes No Comments: _____

Other: Yes No Comments: _____

During the day I like to have a rest/nap: Yes No

Time: _____

Place: _____

My Recreation Life:

My favourite activities are: _____

My favourite games are: _____

My favourite T.V. programs are: _____

My favourite places to go are: _____

My favourite people to get together with are: _____

Other things I enjoy: _____

Feelings

The things that make me happy are: _____

The things that make me sad are: _____

The things that make me upset/angry are: _____

Sometimes I am afraid: _____

You can help me with this by: _____

A day in my life looks like this:

6:30 _____

7:00 _____

7:30 _____

8:00 _____

8:30 _____

9:00 _____

10:00 _____

10:30 _____

11:00 _____

12:00 _____

1:00 _____

1:30 _____

2:00 _____

2:30 _____

3:00 _____

3:30 _____

4:00 _____

4:30 _____

5:00 _____

5:30 _____

6:00 _____

6:30 _____

7:00 _____

7:30 _____

8:00 _____

8:30 _____

9:00 _____

9:30 _____



Haliburton, Kawartha, Peterborough, Northumberland



Host Agency: Northumberland Family Respite Service Inc.
72 Walton Street Port Hope, On L1A 1N3
Phone: 905-885-6671 ext. 227 Fax: 905 885-9758
email: respiteservices.com@northumberlandfamilyrespice.ca