Client Intake Form

Peace of Mind Disability Services

Participant Details

Full Name: _____

Preferred Name: _____

Date of Birth: _____ Gender/Pronouns: _____

NDIS Number: _____

Plan Start Date: _____ Plan End Date: _____

Plan Type: [ ] Agency-managed [ ] Plan-managed [ ] Self-managed

Primary Disability / Diagnosis: _____

Cultural Background / Language: _____

Identify as Aboriginal or Torres Strait Islander? [ ] Yes [ ] No

Interpreter required? [ ] Yes [ ] No

Communication Preferences: _____

Contact Information

Residential Address: _____

Phone Number: _____ Email: _____

Preferred Contact Method: [ ] Phone [ ] SMS [ ] Email

Primary Contact / Guardian

Name: _____

Relationship to Participant: _____

Phone Number: _____ Email: _____

Authority to act on behalf of participant? [ ] Yes [ ] No

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Peace of Mind Disability Services

Support Needs & Goals

Support Required: [ ] Personal Care [ ] Therapy [ ] Community [ ] Daily Living

[ ] Employment [ ] Plan Management [ ] SDA [ ] Transport [ ] Other: _____

NDIS Goals: _____

_____

Emergency Contact

Name: _____

Phone: _____ Relationship: _____

Medical Information

Medical Conditions: _____

Medications: _____

Allergies/Risk Factors: _____

GP Name & Clinic: _____

Phone Number: _____

Consent

By signing below, I consent to:

- Peace of Mind Disability Services collecting and storing my information

- Being contacted about services and supports

- Sharing of information with relevant professionals (with permission)

Signature: _____ Date: _____