Participant Intake Form

Program Name: _____ Date: _____

Participant Information

- **Full Name: _____**
- **Date of Birth: _____**
- **Phone Number: _____**
- **Email Address: _____**
- **Address: _____ _____**
- **Preferred Method of Contact:** ☐ Phone ☐ Email ☐ Text ☐ Other: _____

Emergency Contact Information

- **Name: _____**
- **Relationship to Participant: _____**
- **Phone Number: _____**
- **Email Address: _____**

Medical and Accessibility Information

1. **Do you have a diagnosed physical disability?** ☐ Yes ☐ No
   If yes, please specify (optional):
   _____
2. **Do you use any mobility aids?** ☐ Yes ☐ No
   If yes, please check all that apply:
   ☐ Wheelchair ☐ Walker ☐ Cane ☐ Prosthetic ☐ Other: _____
3. **Do you require any specific accommodations to participate in this program?**
   ☐ Yes ☐ No
   If yes, please specify:
   _____

4. **Do you have any medical conditions we should be aware of?**
   ☐ Yes ☐ No
   If yes, please specify:
   _____

5. **Do you require assistance with daily activities?** ☐ Yes ☐ No
   If yes, please describe the type of support needed:
   _____

Program Participation

6. **What are your goals for participating in this program?**

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7. **What activities or services are you most interested in?**
   ☐ Advocacy & Community Support
   ☐ Employment & Workforce Development
   ☐ Wellness & Health Services
   ☐ Social & Recreational Activities
   ☐ Other: _____

8. **Do you have any concerns or challenges you would like us to be aware of?**

Consent & Agreement

I acknowledge that the information provided above is accurate to the best of my knowledge. I understand that participation in this program is voluntary and that any personal data collected will be kept confidential and used only for program-related purposes.

- **Participant Signature: _____**
- **Date: _____**
- **Guardian/Caregiver Signature (if applicable):**
  _____
- **Date: _____**