Families of Alberta for
Conductive Education

Adult Assessment Questionnaire

A completed questionnaire is required for each new attendee who is interested in Conductive Education. Due to the high contact and physical nature of our work please complete the questionnaire as fully as possible.
This information will be kept confidential. Please return to info@facealberta.ca.

First name:	Initial(s):	Last name:
Name Commonly Used:	Date of Birth (mm/dd/yy):	
Address:	City:	
Province:	Postal Code:	
Access Registration #:	Access Password:	
Male or Female:		
Mother's/Guardian's Name:	Father's/Guardian's Name:	
Home #:	Home #:	
Cell #:	Cell #:	
E-mail:	E-mail:	
Address:	Address:	
City:	City:	
Province: Postal Code:	Province: Postal Code:	
Lives with: ☐ Family ☐ Independently	☐ Guardian/Support Worker(s)	

Emergency Contacts:

#1 Contact:	Relationship:
Cell #:	Home #:
#2 Contact:	Relationship:
Cell #:	Home #:

Doctor Information:

Primary Physician:	Phone #:
Specialist (Type & Name):	
Phone #:	

1. Diagnosis: ____________________

Date of Diagnosis (mm/dd/yy):____________

2. Complete description of your diagnosis (include secondary implications of the primary diagnosis). Use a separate sheet if necessary.

____

____

3. Medical Conditions: Please describe any medical conditions (e.g., heart problem, seizures, etc.) that you have:

____

____

4. Medications (including prescription and non-prescription medications, PRN medications (ex. Advil, Midol etc.) and herbal remedies): Please list any medications taken. Write the route and time that medications are administered.

Medication (purpose):	Route (eg. by mouth, g-tube etc.) & Time taken:
____________	____________________
____________	____________________
____________	____________________

5. Please circle Yes or No and give the approximate date(s):

Condition		Date (mm/dd/yy) (approx)	Condition		Date (mm/dd/yy) (approx)
Chicken Pox	Yes No	________	Heart Condition	Yes No	________
Fainting	Yes No	________	Adenoidectomy	Yes No	________
Asthma	Yes No	________	Hernia Repair	Yes No	________
Tuberculosis	Yes No	________	Kidney Trouble	Yes No	________
Tonsillectomy	Yes No	________	Measles, German	Yes No	________
Hepatitis	Yes No	________	Whooping Cough	Yes No	________
Mumps	Yes No	________	Hay Fever	Yes No	________
Measles, Red	Yes No	________	Diabetes	Yes No	________
Severe Stomach	Yes No	________	Scarlet Fever	Yes No	________
Frequent Colds	Yes No	________	Sinus Trouble	Yes No	________

6. Operations: State any operations that you have had and indicate which were related to your primary diagnosis:

____

____

7. Have you had any major illnesses recently?

____

8. Give the last approximate dates of immunizations:

Immunization	Date (mm/dd/yy)	Immunization	Date (mm/dd/yy)
Tetanus	____________	Diphtheria	____________
Polio	____________	HIB	____________
Pertussis	____________	Other	____________

9. Do you have any allergies?

____

____

10. Please describe symptoms of allergic reaction & intervention required:

____

____

11. Allergy Medication?

Carries Ana kit: ☐Yes ☐No ______________________________________

Carries Epipen: ☐Yes ☐ No ______________________________________

☐Other ______________________________________

12. What category do you qualify? ☐AISH ☐PDD ☐BOTH ☐None

13. What best describes your situation?

☐ Family Managed Support ☐ PDD program Full Time ☐ Independent Living

Other: ____

14. Motor Development (check the most appropriate answer/s):

☐Using a wheelchair full time (Electric) (Manual but independent) (Manual and requires pushing)

☐Uses a wheelchair sometimes but can use walker, canes or can step independently (Please elaborate)____

☐Uses walker or canes everyday

☐Walks independently

15. Medication

☐ Able to take medication independently

☐ Takes medication in food (crushed or whole)

☐ Can take medication with assistance

☐ Requires full assistance with medication (takes medication in g-tube)

16. Speech and Language

☐ Able to speak full sentences and follow instructions
☐Can follow instructions but my speech is sometimes unclear to others
☐Can follow instructions but require AAC to engage in conversation
☐Require additional time to follow instructions and requires additional time to respond
☐Other (please describe) ____

16. Hearing
☐ No concerns
☐ Please describe you additional needs in relation to your hearing:

____

17. Vision

☐ No concerns
☐ Please describe you additional needs in relation to your vision:

____

18. Self-care skills

☐ Eat, drink and takes self to the bathroom independently
☐ Requires help in the bathroom, but can eat and drink when I am set up with what I need
☐ Requires help in the bathroom and help to eat and drink
☐ Other:

____

19. Please describe any treatment or therapies that you have received in the past and not currently receiving, including Conductive Education.

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20. Please describe any programs you are registered to help you progress towards your goals:

____

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21. Please detail all the equipment and aids that you use (AFOs, special shoes, leg/arm immobilizers, walkers, wheelchairs, standing frame etc.)

22. Do you classify as a person with emotional or behavioural challenges? If yes please describe challenges and interventions used.

23. Please list a minimum of three goals for this program.

Declaration and Signature

I hereby state that the above information is true to the best of my knowledge

Client Signature

Date

On Behalf of client (Please state relationship)

Date