TAP UNLIMITED Intake Form

Contact Information

Name of Client	
Support Person/Contact	
Street Address	
City ST ZIP Code	
Home Phone	
Work/Cell Phone	
E-Mail Address*	

most of the communication for TAP Unlimited is sent via email. Please provide an email address of a close friend or relative if possible. If you do not have access to email/computer, a TAP buddy will be assigned to you and they will phone you with any changes/important notifications re: TAP programming.

How did you hear about TAP: ____

Background Information:

Date of Birth: ___ / ___ / ________ Age: _______

Please check all that apply:

- ☐ Stroke: date(s): ___________________________________
- ☐ Brain Injury: type and date: _________________________
- ☐ Primary Progressive Aphasia or other FTD
- ☐ Other Neurological Impairment: explain: ____
- ☐ Allergies
- ☐ Seizures
- ☐ Glasses? _____________________________
- ☐ Hearing? _____________________________

Please note any special needs or physical limitations:

____

***Please note**: To participate in Aphasia Day or other extended group programs, an individual must be independent in ambulation, transfers and toileting OR have a support person who will assist the client with these needs. TAP will not be available/able to offer that type of assistance.*

Social History

Educational Level: ____

Language(s): ____

Career / Type of Work: _________________________________ retired? ___________

Volunteer Position(s): ____

Current Living Situation: ____

Born and Raised: ____

Circle: married widowed single divorced

Children

Name	Age	Spouse	Location

Grandchildren

Name	Age	Location

Names (and relationship) of other significant individuals:

Activities

TAP Unlimited is based on a Life Participation Approach to Aphasia (LPAA) … it is essential that an individual wishing to participate in the program consider what goals, interests or activities they wish to return to, or perhaps, become involved in for the first time. TAP will help design hierarchies to meet those needs and modify strategies for communication as they continue in their pursuits.

WORK, SPORTS, RECREATIONAL, HOBBIES, INTERESTS….

BARRIERS YOU PERCEIVE TO PARTICIPATION/ENJOYMENT IN THESE ACTIVITIES…

Describe a typical day for the client:

Before Aphasia:

After Aphasia:

What roles/responsibilities have changed as a result of the aphasia?

Favorites
Foods/Restaurants:
Entertainment (music/shows/film,etc.):
Reading/Writing Interests:
Use of Computer:

SPEECH THERAPY HISTORY

Please list types/amount of speech therapy you / the client have been involved in and include, with this intake, the latest speech pathology summary/report.

Please provide names of professionals involved in the clients care and sign on each line for release of information from that professional/agency to TAP (i.e. Dr. Smith Raleigh Neurology your signature). Please include programs, support or recreational, that the client is involved in.

Provider Name	Affiliation	Release information to TAP (signature)

Please send the completed form to:
TAP Unlimited
191 High House Road
Cary, NC 27511
OR
info@aphasiaproject.org

Thank you for your interest in TAP Unlimited. This nonprofit organization is designed with your needs in mind and feedback/involvement in all programs is very important to us.