

- iContact     Dbase
- Snapshot     Research
- 

## Contact Information

Name of Client	
Street Address	
City ST ZIP Code	
Home Phone	
Work/Cell Phone	
E-Mail Address*	
Name & Relation of Support Person	
Support Person Contact Information	
Today's Date	

***\*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, a TAP buddy will be assigned to you and they will phone you with any changes/important notifications about 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: TAP staff and volunteers are unable to assist clients with ambulation, transfers or toileting; support persons are welcome at all TAP events/groups.***

## 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 relevant professionals involved in client care. Sign on each line for release of information from that professional/agency to TAP, Unlimited (i.e. Dr. Smith, Raleigh Neurology, your signature).

Provider Name	Affiliation	Release information to TAP (signature)

**Please send the completed form to:**

**TAP Unlimited**  
**191 High House Road**  
**Cary, NC 27511**  
**919-650-3854**

---

For office use only below this Line

Communication Strategies

Strengths

Suggested Groups

Other