ABOUT ME

Complete this form and use as an additional aid for information about you. Take this form to a first-time visit with a health care practitioner.

Hello	My name is	I like to b	e called
important that you se with a disability and communicate. Toget	ee me as a person first and that y I would like to use this paper to he ther we can understand what's g	his appointment and I want us to b you treat me like all of your other p nelp you understand how my disab oing on with me. My support perso	atients. I am an individual lity affects me and how I
you want me to do af	ter we leave today.		
Insurance			
MA#			
The person with me i	S:		
My support group			
Family member(s)		Personal Care Attendant	
Job coach		Neighbor	
Guardian		Interpretor	
Case Manager		Other	
I am working:			
My job is:			
Hours a week:			
My allergies includ	le:		
Food			
Medicine			
Other (latex, etc.)			
What I want you to	know about how my disabili	ty affects me:	
My triggers and/or se	ensitivity issues are:		

Medicine	Directions/ dosage	Purpose	F	Prescribed by	Date Started
	MEDICA	ATIONS I AM	CURRENTLY TAKIN	NG:	
Other			Other		
In a group home		Transportation			
My family home			Preparing meals		
Supported living environment			Taking medication		
My own home/ apartment			Personal cares Filling prescription	ons	
My living Situation:				others to help m	ne with are:
Sign language		the details of what you tell me			
have information vritten down			I rely on the pers		
Pictures			I like simple term step by step dire		
Computer/ other communication device			I can understand		
can communicate thro	ough:		Understanding:		
Other					
I would like to be examined in my chair					?
I need to be lifted onto the exam table			neip you undersi	tanu	
I need help to get on the exam table			My companion c		
I use a wheelchair			I am deaf/hard of hearing	of	
I walk slowly or with a walker		I cannot speak			
I walk unaided	I can speak for myself. Please, try to listen				

Communication:

Physically: