Ray Graham Association®

Empowering people with disabilities to reach, grow, and achieve.™

Illinois Council on Developmental Disabilities

Health Resume

ALL ABOUT ME

My Full Name Is	Please Call Me	 Click to add my photo
My Date of Birth Is	Form completed on	
My race	My primary language is	
My sex	I identify as	

HOW I COMMUNICATE

To communicate, I use No assist needed

Speech Clarity I have clear speech

Comprehension I understand normal speech

Decision Making I make decisions independently

My pain signs	☐ Self-Injury Behavior ☐ Fetal Position	☐ Crying ☐ Grimacing	☐ Flinching ☐ Screaming	Other
My fear signs	☐ Physical Agitation ☐ Non-responsive ☐ Still	☐ Crying ☐ Grimacing ☐ Rapid Breathing	☐ Flinching ☐ Screaming	Other
My anxiety triggers	☐ Loud Noises ☐ Crowds ☐ Needles ☐ Separation from favored person	☐ Touch ☐ Men ☐ Procedures	☐ Masks ☐ Women	Other
My calming techniques	☐ Music ☐ Explain Service ☐ Favored person	☐ Light Touch ☐ Massage ☐ Soft Speech	☐ Books ☐ Dim Light	Other

ALL ABOUT ME

How I react to meeting new people

What is important/non-negotiable to me

What makes me comfortable	What makes me uncomfortable

What people appreciate about me

How to best support me

I live independently

MY BRIEF MEDICAL HISTORY

My risks

☐ Implants ☐ Pacemaker ☐ Falls ☐ Feeding Tube ☐ Aspiration
☐ Seizures ☐ Pressure injury ☐ VNS ☐ Shunts ☐ Prosthetics
☐ Joint Replacement ☐ NPO *(Nothing by mouth)* ☐ Cannot bear weight ☐ Other

I am oriented

☐ to Person *(knows their name)*
☐ to Place *(knows where they are)*
☐ to Time *(knows current day/time)*

My vision Normal Vision

My hearing Normal Hearing

If I have a DNR, it is on file at

My oxygen usage

My allergies / dietary restrictions

☐ My current medical administration form including diagnosis and allergies is attached

Has a mental health declaration been signed? ☐ Yes ☐ No

Check all that apply

☐ Autism ☐ Developmental Disability ☐ Intellectual Disability ☐ Dementia/cognitive decline
☐ Down Syndrome ☐ Cerebral Palsy ☐ Epilepsy ☐ Liver disease ☐ Heart disease
☐ Kidney Disease ☐ Diabetes ☐ Smoker ☐ Homeless ☐ Long-term care resident
☐ HIV/AIDS ☐ Pregnant ☐ Emphysema ☐ Age 65 or older ☐ Severe obesity (>40 BMI)
☐ Corticosteroid use ☐ Substance use ☐ Cancer ☐ COPD ☐ Asthma
☐ Immunocompromised ☐ Other cognitive/severe communication disorder

My major surgeries and other health concerns

A detailed history of bowel condition, dehydration, sepsis, gastroesophageal reflux disease (GERD), or urinary tract infection (UTI), if applicable

How I use the bathroom

☐ Incontinent to Bowel
☐ Incontinent to Bladder
☐ Urinal
☐ Commode
☐ Diapers
☐ Needs Bathroom Assist
☐ Raised Commode
☐ Other

Self-care and mobility

Handedness Right
Dressing Some Assist
Bathing Some Assist
Oral Care Some Assist
Peri-Care Some Assist
Hair Care Some Assist
Drinking Some Assist
Sitting to standing Some Assist
Transfers to bed Some Assist
Walks ten feet Some Assist

My diet and nutrition

☐ Regular ☐ Soft ☐ Puree ☐ Chopped ☐ Mechanical
☐ Feeding Tube ☐ Thickened Liquids ☐ History of Aspiration ☐ Nothing by Mouth

My favorite foods/drinks

How to help me eat

My oral status

☐ Own teeth ☐ Dentures ☐ No teeth ☐ Missing teeth

How to reposition me *(and BRADEN scale score if known)*

Any other information about me

MY TEAM'S INFORMATION			
My legal representative		Phone	Email
My case manager (QIDP)		Phone	Email
A family member	Relationship	Phone	Email
A family member	Relationship	Phone	Email
My Primary Physician		Phone	Email
Organization(s) supporting me		Phone	Email
The support team has assigned the following person to be my primary contact for medical information:			

Prepared with and for me by my Interdisciplinary Support Team.