

Person-Centered

PROFILE

Name: _____

Who I Am:

About Me:

Age: _____

Day
Program: _____

Live with: _____

Pets: _____

Guardian/Emergency Contact Info.:

Name: _____

Phone: _____

Name: _____

Phone: _____

Name: _____

Phone: _____

Things I Love: 

| | |
|---|---|
|  _____ |  _____ |
|  _____ |  _____ |
|  _____ |  _____ |
|  _____ |  _____ |
|  _____ |  _____ |
|  _____ |  _____ |
|  _____ |  _____ |







Hopes, Dreams, Expectations:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Strengths & Gifts:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____













What I Am Working on, Learning:

| | |
|---|---|
|  _____ |  _____ |
|  _____ |  _____ |
|  _____ |  _____ |













Person-Centered

PROFILE - CONT.

What Works for Me:

| | | | |
|---|-------|---|-------|
|  | _____ |  | _____ |
|  | _____ |  | _____ |
|  | _____ |  | _____ |
|  | _____ |  | _____ |
|  | _____ |  | _____ |
|  | _____ |  | _____ |

What Doesn't Work for Me:

| | | | |
|---|-------|---|-------|
|  | _____ |  | _____ |
|  | _____ |  | _____ |
|  | _____ |  | _____ |
|  | _____ |  | _____ |
|  | _____ |  | _____ |
|  | _____ |  | _____ |











Medical Diagnoses:

| | |
|--------------------------|-------|
| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |

Medication Side Effects:

| | |
|--------------------------|-------|
| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |
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| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | _____ |

Other Helpful Things to Know

| | | | |
|---|-------|---|-------|
|  | _____ |  | _____ |
|  | _____ |  | _____ |
|  | _____ |  | _____ |
|  | _____ |  | _____ |
|  | _____ |  | _____ |