Client Assignment and Registration System
Texas Department of Mental Health and Mental Retardation

CARE-PC1 **Client Physical Characteristics** (Action Code 335) Rev. 1/03

Last Name/ Suffix ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐ Client ID ☐☐☐☐☐☐☐☐☐☐

First Name ☐☐☐☐☐☐☐☐☐☐☐ Local Case Number ☐☐☐☐☐☐☐☐☐☐

Middle Name ☐☐☐☐☐☐☐☐☐☐ Component/Location ☐☐☐ ☐☐☐☐

Action Add: ☐ Change: ☐ Delete: ☐

<u>Impairment</u>

Health Status ☐
1 = No Major Problems, 2 = Mild
3 = Moderate, 4 = Severe

Mobility ☐
1 = Unimpaired, 2 = Mild
3 = Moderate, 4 = Mobile/Non-Ambulatory
5 = Non-Ambulatory

Coordination ☐
1 = Unimpaired, 2 = Reduced, 3 = Disabling

Hearing Loss ☐
1 = None, 2 = Mild, 3 = Moderate
4 = Moderately Severe, 5 = Severe
6 = Profound

Visual Handicap ☐
1 = None, 2 = Mild, 3 = Moderate, 4 = Severe

Speech Handicap ☐
1 = None, 2 = Mild, 3 = Moderate, 4 = Severe

Behavior Management ☐
1 = None, 2 = Mild, 3 = Moderate
4 = Severe, 5 = Profound

<u>Prosthetics</u>

	Yes	No
Hearing Aid	☐	☐
Dental Prosthetics	☐	☐
Corrective Lenses	☐	☐
Wheelchair	☐	☐
Walker/Cane	☐	☐
Orthopedic Shoes	☐	☐
Orthopedic Appliances	☐	☐
Special Positioning Equipment	☐	☐
Adaptive Eating Devices	☐	☐
Augmented Communication Devices	☐	☐
Other: ____________	☐	☐

Completed By: ______________________ Date: ____________

Title: ______________________

Client Physical Characteristics (**CARE-PC1**)

Field Name	Type	Contents
LAST NAME	R	Person's last name.
SUFFIX	O	Person's last name suffix. (e.g., Jr, Sr, II)
FIRST NAME	R	Person's first name.
MIDDLE NAME	O	Person's middle name.
CLIENT ID	O	Person's statewide identification number.
LOCAL CASE NUMBER	R	Person's local case number.
COMPONENT	R	Component code.
LOCATION	R	Location code.
ACTION ADD	O/R	You must check this box if data is to be added to CARE.
ACTION CHANGE	O/R	You must check this box if data is a change to data already in CARE.
ACTION DELETE	O/R	You must check this box if data is to be deleted from CARE.
Impairment		
HEALTH STATUS	R	One-digit code describing the person's health status. **Decode: Health Status**
MOBILITY	R	One-digit code describing the person's mobility status. **Decode: Mobility**
COORDINATION	R	One-digit code describing the person's level of coordination. **Decode: Coordination**
HEARING LOSS	R	One-digit code describing the person's level of hearing loss. **Decode: Hearing Loss**
VISUAL HANDICAP	R	One-digit code describing the person's level of visual impairment. **Decode: Visual Handicap**
SPEECH HANDICAP	R	One-digit code describing the person's level of articulation and language usage. **Decode: Speech Handicap**
BEHAVIOR MANAGEMENT	R	One-digit code describing the person's behavior management problems. **Decode: Behavior Management**
Prosthetics		
HEARING AID	R	Check *Yes* or *No* indicating whether or not this prosthesis is currently required by the person on a daily basis.
DENTAL PROSTHETICS	R	Check *Yes* or *No* indicating whether or not this prosthesis is currently required by the person on a daily basis.
CORRECTIVE LENSES	R	Check *Yes* or *No* indicating whether or not this prosthesis is currently required by the person on a daily basis.
WHEELCHAIR	R	Check *Yes* or *No* indicating whether or not this prosthesis is currently required by the person on a daily basis.

Field Name	Type	Contents
Prosthetics, continued		
WALKER/CANE	R	Check *Yes* or *No* indicating whether or not this prosthesis is currently required by the person on a daily basis.
ORTHOPEDIC SHOES	R	Check *Yes* or *No* indicating whether or not this prosthesis is currently required by the person on a daily basis.
ORTHOPEDIC APPLIANCES	R	Check *Yes* or *No* indicating whether or not this prosthesis is currently required by the person on a daily basis.
SPECIAL POSITIONING EQUIPMENT	R	Check *Yes* or *No* indicating whether or not this prosthesis is currently required by the person on a daily basis.
ADAPTIVE EATING DEVICES	R	Check *Yes* or *No* indicating whether or not this prosthesis is currently required by the person on a daily basis.
AUGMENTED COMMUNICATION DEVICES	R	Check *Yes* or *No* indicating whether or not this prosthesis is currently required by the person on a daily basis.
OTHER	R	Check *Yes* or *No* indicating whether or not this prosthesis is currently required by the person on a daily basis.
COMPLETED BY	R	Signature of person completing form.
DATE	R	Date form is completed.
TITLE	R	Title of person completing form.

This page was intentionally left blank.