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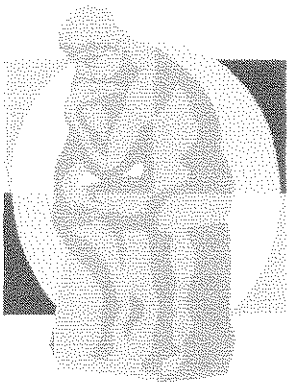


The activities in this book are inventory tools, designed to help you think about transitions. They are intended for your personal use. You may choose one or more to help think through some aspects of an upcoming transition.

Preparing for Transition

Preparing for Transition - My Personal Inventory

These are some things that I want to think about as I plan for my life transition

from _____ to _____

My Preferences/Interests

My Learning Style

My Health

My Leisure Time Choices

The Schooling that I have....

The Schooling that I still need....

Who am I?

Mark (×) the ones that describe you

I am:

- [ ] **Reliable**
- [ ] **Honest**
- [ ] **Respectful**
- [ ] **Polite**
- [ ] **Patient**
- [ ] **Generous**
- [ ] **Thoughtful**
- [ ] **Gentle**
- [ ] **Kind**
- [ ] **Friendly**
- [ ] **Proud**
- [ ] **Confident**
- [ ] **Energetic**
- [ ] **Cooperative**
- [ ] **Flexible**
- [ ] **A good listener**
- [ ] **Easy to get along with**
- [ ] **Fun to be with**
- [ ] **Willing to learn**
- [ ] **Hard working**
- [ ] **A good friend**
- [ ] **Neat and organized**
- [ ] **A good team member**
- [ ] **Usually on time**
- [ ] **Good with words**
- [ ] **Good with my hands**
- [ ] **Good with mechanical things**
- [ ] **Happier doing things by myself**
- [ ] **Usually happy**
- [ ] **Good at helping others**

What else?

_____

_____

_____

_____

_____

_____

After you complete this activity, share it with a friend. See if they agree/disagree with your choices.

Who Am I?

Who am I?

What do I do well?

What are my successes?

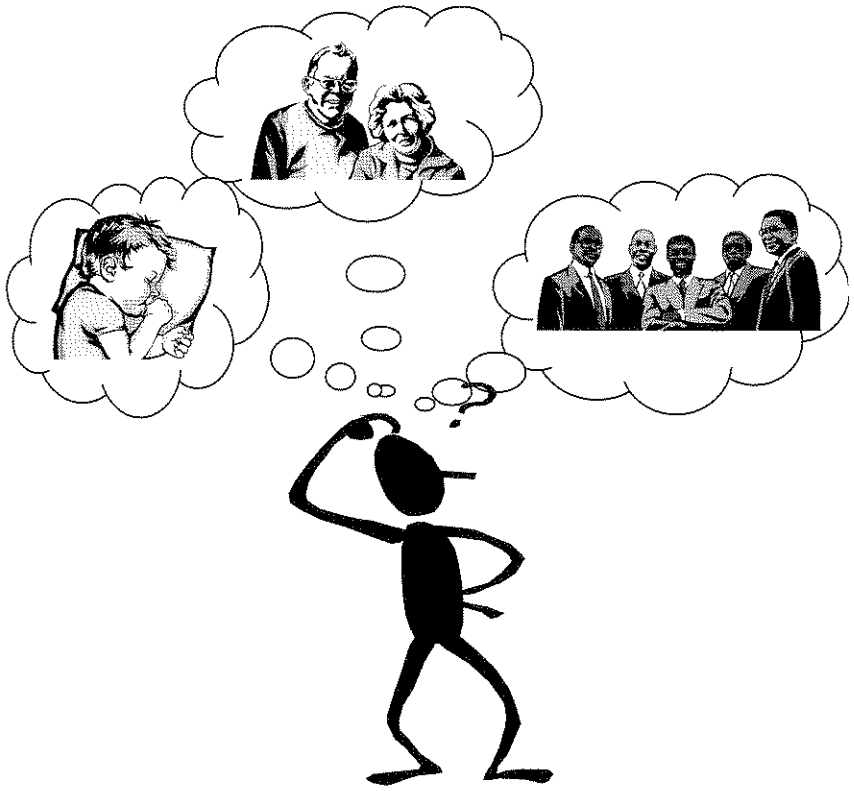
What challenges me?

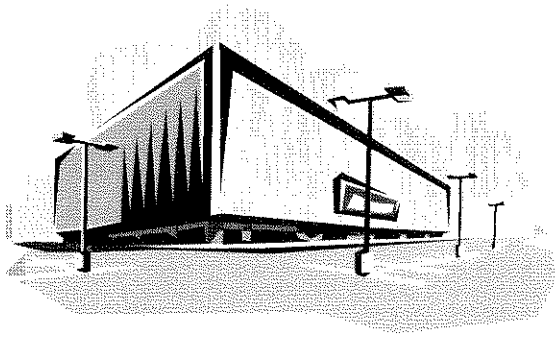
What is my dream job?

Use short answers or just jot down some ideas.
Share with a friend.

I Prefer:

- [ ] Working with people
- [ ] Working alone
- [ ] Having close supervision
- [ ] Being in charge
- [ ] Being mostly with women
- [ ] Being mostly with men
- [ ] Caring for older people
- [ ] Caring for children
- [ ] Caring for babies



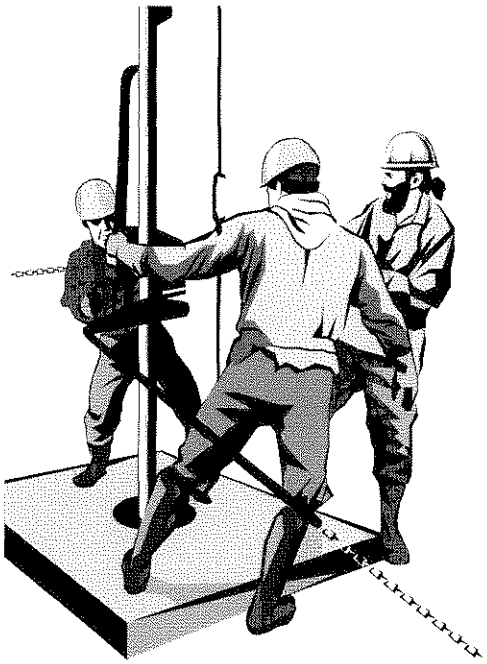


Where?

- [ ] Being outside
- [ ] Being indoors
- [ ] Being in a large place
- [ ] Being in a small place
- [ ] A big company
- [ ] Small shop

I Prefer:

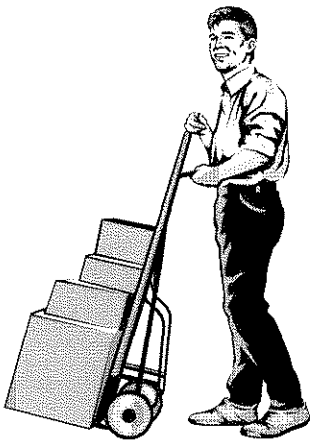
- [ ] Sitting most of the time
- [ ] Standing most of the time
- [ ] Staying in one place
- [ ] Moving around
- [ ] Traveling
- [ ] Staying close to home

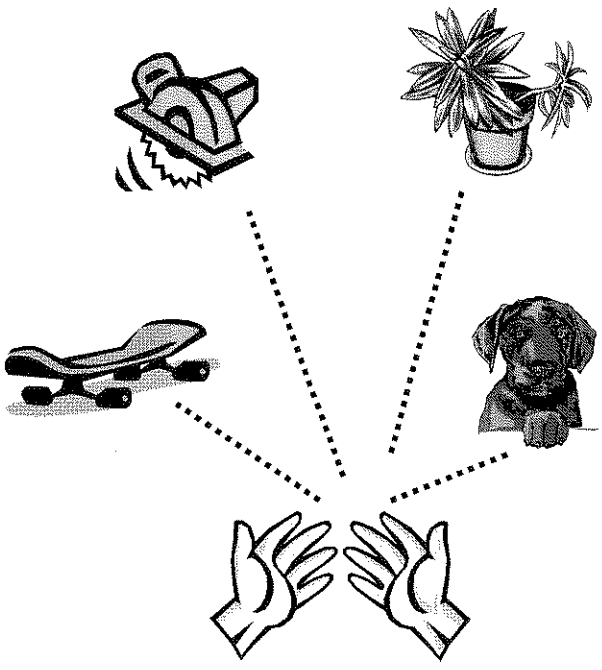


- [ ] Having a regular schedule
- [ ] Having a flexible schedule
- [ ] Doing different things
- [ ] Doing the same things
- [ ] Learning new things
- [ ] A fast pace
- [ ] A slow pace
- [ ] Getting paid well

I Prefer:

- ☐ Using your hands
- ☐ Using your strength
- ☐ Using your ideas
- ☐ Talking
- ☐ Producing
- ☐ Fixing
- ☐ Maintaining
- ☐ Assembling
- ☐ Planning
- ☐ Organizing
- ☐ Operating

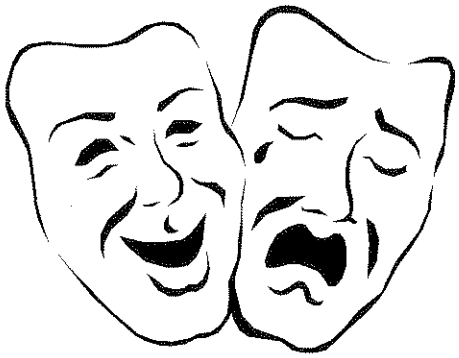




- ☐ Using tools
- ☐ Handling paper
- ☐ Handling wood
- ☐ Handling metal
- ☐ Handling clothing
- ☐ Handling appliances
- ☐ Handling sports equipment
- ☐ Handling toys
- ☐ Handling plants
- ☐ Handling animals

I Prefer:

- [ ] Dressing casual
- [ ] Dressing businesslike
- [ ] Wearing a uniform
- [ ] Getting dirty
- [ ] Staying clean



Comforts and Concerns:

I am most comfortable with _____

_____

_____

My favorite place is _____

_____

_____

My favorite activities are _____

_____

_____

	Being alone		Needing help
	Being in a crowd		Being a bother
	Having no friends		Being physically hurt
	Not knowing anyone		Getting my feelings hurt
	Talking to people I don't know		Failing
	Being ignored		Embarrassing myself
	Not being understood		Embarrassing my family
	Not understanding		Embarrassing my friends
	Not knowing the answer		Not having a chance
	Making a mistake		Not having control over my life
	Saying the wrong thing		Not being myself
	Being laughed at		Being rejected
	Being different		Being told "no"
	Hurting someone's feelings		The future

Leisure Time
What Do I Like to Do?

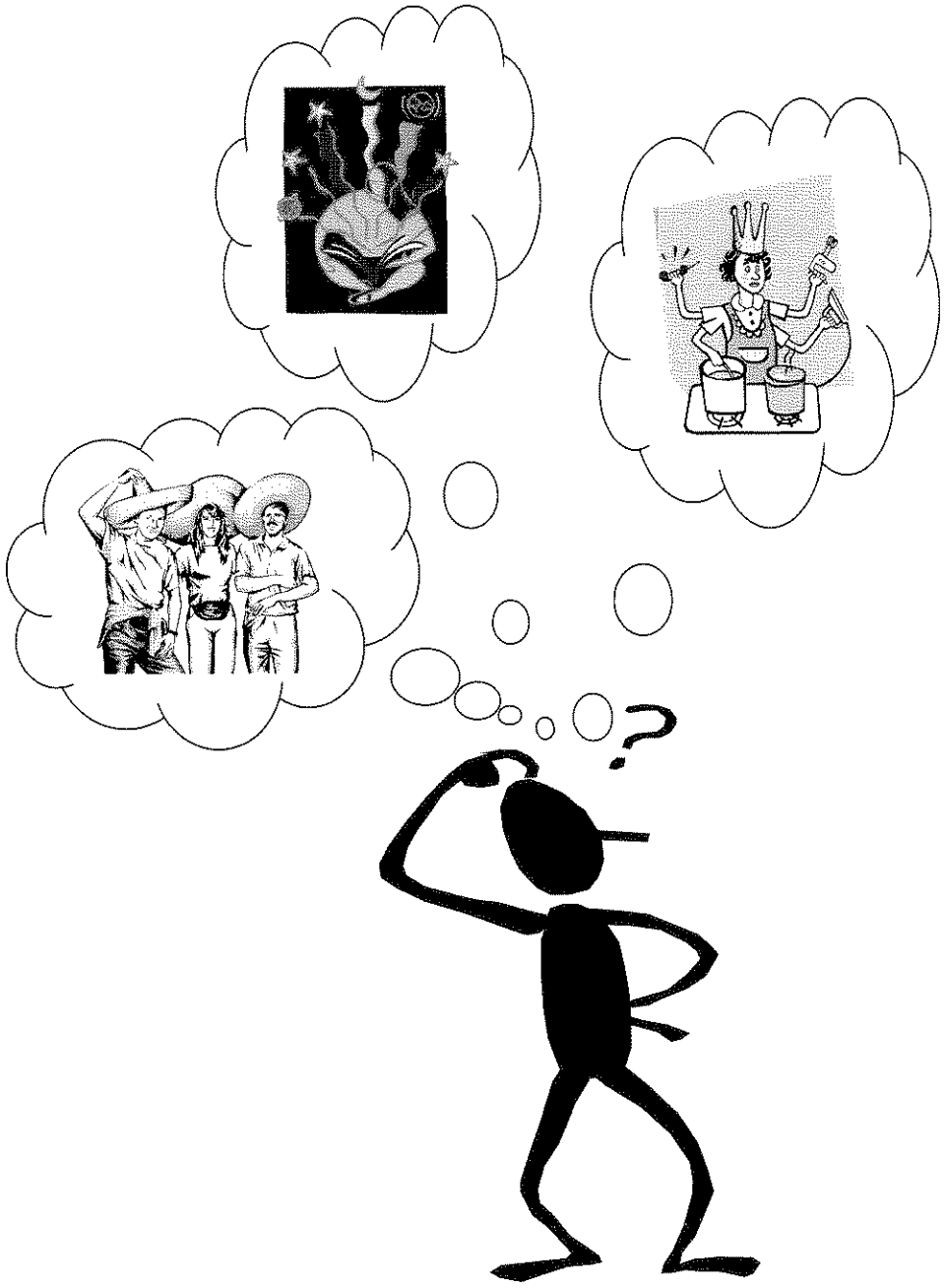
Can you explain one of your choices to a friend/family member?

- Walking
- Jogging
- Swimming
- Bicycling
- Skateboarding
- Frisbee
- Photography
- Rollerblading
- Hiking
- Basketball
- Other

- Other
- Football
- Hockey
- Soccer
- Tennis
- Bowling
- Horseback Riding

Leisure Time
What Do I Like to Do?

Drawing	
Painting	
Collecting things	
Card games	
Video games	
Computer games	
Board games	
Reading	
Listening to Music	
Watching TV	
Going to the Movies	
Cooking	
Shopping	
Hanging with friends	
Dancing	
Writing music	
Going out to eat	
Other Ideas	



What is it about this that makes it fun? a hobby? an interest?

Household Chores/Choices

Cleaning

- [ ] Emptying garbage
- [ ] Clearing table
- [ ] Washing Dishes
- [ ] Dusting
- [ ] Sweeping
- [ ] Laundry
- [ ] Changing sheets
- [ ] Vacuuming
- [ ] Picking up
- [ ] Recycling
- [ ] Making my bed
- [ ] Emptying dishwasher

Cooking

- [ ] Making toast
- [ ] Using toaster oven
- [ ] Using the microwave
- [ ] Making coffee
- [ ] Using the stove
- [ ] Using the oven
- [ ] Using a can opener
- [ ] Using a food processor
- [ ] Peeling potatoes
- [ ] Making dinner
- [ ] Following a recipe

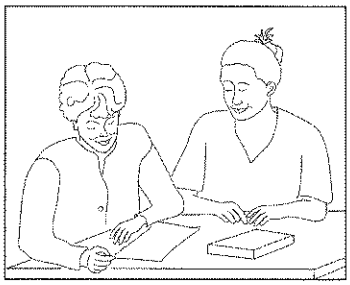
Gardening

- [ ] Watering
- [ ] Sweeping
- [ ] Shoveling
- [ ] Raking
- [ ] Mowing
- [ ] Weeding
- [ ] Clipping
- [ ] Edging
- [ ] Planting
- [ ] Fertilizing

Health and Wellness

	I can phone for help.
	I know how to lock my front door.
	I know how to lock the windows in my home.
	I can use a fire extinguisher.
	I check our smoke alarms.
	I use electrical appliances safely.
	I put cleaning supplies away from animals and small children.
	I know when to see a doctor.
	I take care of minor cuts myself.
	I take the medicine my doctor gives me.
	I maintain a healthy diet by making good food choices.
	I order/buy food that supports healthy living.
	I make my own doctor appointments.
	I know the names, addresses, and phone numbers of my doctors.
	I know where the emergency contacts are posted.
	I can use a cell phone to call for help.
	I know CPR.
	I know how to call for help.
	I know how to plan an exercise activity.
	I know who to call to plan an activity.
	I can get information about local events that support good health.

Health History Summary



As you make the transition from pediatric to adult health care, you will be assuming more responsibility for your health care. When you go to your new adult doctor (or other health care provider), you will be asked about major health events in your life. ***Have a parent help you fill out this form*** *and take it with you when you go to your new adult care doctor (or other health care provider) and you will be prepared for the questions that you will be asked.*

How would you describe your overall general health? (Please circle one and add comments if you want to)

Fair Good Excellent

What are your special health care needs? Is there anything in particular that your doctor needs to know about your special needs?

As a child and teenager, what were your major health problems?

What medications are you **currently** taking?

Medications:	What is it taken for?	How Much? (Dose)	How Often? (Schedule)

Health History Summary

Allergies or adverse reactions to medications

Are there any medications that you have taken that have caused you problems?

Medication	Reasons no longer taking medication

Food or other allergies: (include bee stings)

Food or substance	Reaction and Treatment

Past medical history:

Your birth weight _____ Were you born early? _____ If so, how many weeks early? _____

Did your mother have any problems with her pregnancy or delivery of you? _____

Were you hospitalized at the time of your birth? _____ If yes, how many days? _____ Or weeks? _____

What problems did you have at birth?

_____

_____

_____

_____

_____

Please list any serious illnesses you have had and any injuries that included loss of consciousness.

_____

_____

_____

_____

_____

Please list hospitalizations and surgeries you have had and include the dates and places.

_____

_____

_____

_____

_____

Health History Summary

Personal health history: Have YOU ever had the following:

Condition:	Yes	Age
Anemia		
Asthma		
Blood Transfusion		
Cancer		
Constipation		
Diabetes		
Ear Infections		
Eating Problems		
Heart Disease		
Hepatitis		
Seizures (Epilepsy)		
Tuberculosis		
Attention Deficit Disorder		

Condition:	Yes	Age
Depression		
Suicide attempt		
Conduct Disorder		
Anxiety		
Learning Disability		
Developmental Delay		
Eating Disorder		
Other Conditions not Listed:		

If the answer is yes to any of the above conditions please use this space to make any additional comments about the conditions. **For individuals with seizures,** describe the seizures and include how often the seizures occur, how long they last, and when was your last one?

What tests have previously been done for these conditions, what were the results, and where were they done? (MRI? CT? EEG? EKG? Genetic Testing? Blood Tests? Psychological Testing?)

What treatments have been tried for these conditions and what was the most successful?

Are the conditions the (please circle one): (same) (improving) (getting worse)

Health History Summary

Resource Information:

School: _____ Grade in School: _____

Do you have an Individualized Education Plan (IEP)? _____ Do you have a 504 plan? _____

Name of contact person at school _____ Telephone: _____

Do you use Vocational Rehabilitation services? _____ Contact person at DVR _____

Recent medical records:

List the name, address, and telephone number of any doctors or other health care provider who have the latest medical records about your health conditions.

Name	Specialty	Address	Telephone #

Other resources:

List the name, address, & telephone number of any other person that has worked with you in regard to your health condition in the past two years (such as a physical therapist, pharmacist, medical supply house, caseworker, school nurse, etc.).

Name	What They Do	Address	Telephone #

Your immunization dates: (Or attach a copy of your immunization record)

DPT/DT	1.	2.	3.	4.	5.
TD	1.	2.	3.	4.	5.
OPV	1.	2.	3.	4.	5.
MMR	1.	2.			
HIB	1.	2.	3.	4.	
Hep B	1.	2.	3.	4.	
Varicella	1.	2.			

Health History Summary

Family Health History: Have any of your blood relatives had the following:

Condition:	Relation
Anemia	
Breast Cancer	
Cancer (Other)	
Diabetes	
Heart attack	
High Blood Pressure	
High Cholesterol	
Seizures	
Sickle Cell Anemia	
Stroke	
Thyroid Problems	
Tuberculosis	

Condition:	Relation
ADD/ADHD	
Alcoholism	
Depression	
Drug Abuse	
Learning Disability	
Manic Depressive	
Suicide	
Schizophrenia	
Other Conditions?	

Comments:

Insurance Coverage Information:

Insurance	Policy number	Telephone number

Do you receive social security income (SSI)?	YES	NO
Do you receive medical benefits through the SSI program?	YES	NO

Emergency Contacts:

Name	Relationship	Telephone numbers
		(W) (H)
		(W) (H)

Health History Summary

Activities of Daily Living

	YES	NO
Are you visually impaired?		
Do you wear glasses or contacts?		
Are you deaf or hard of hearing?		
Do you use a hearing aid?		
Do you have any speech problems?		
Do you use sign language?		
Is English your preferred language? If no, what language do you speak?		
Can you walk?		
Do you use a walker?		
Do you use a wheelchair?		
Do you routinely wear medic alert identification?		

What other aids do you use to accomplish daily activities?

Are there any restrictions to your daily activities? (Can you drive an automobile? Do you need a computer to communicate? Etc.)

Your adult doctor will ask you questions in private about your sexuality, about drug and alcohol and cigarette use.

Academic Summary – a worksheet

Year in School		(×)
	Eighth (8)	
	Freshman (9)	
	Sophomore (10)	
	Junior (11)	
	Senior (12)	
	Super Senior (13+)	

Courses I have already taken

	(×)		(×)		(×)		(×)		(×)
English I		English II		English III		English IV		English Elective	
Math I		Math II		Math III		Math IV		Math Elective	
Science I		Science II		Science III		Science IV		Science Elective	
Social Studies		US History		US History		Social Studies		SS Elective	
Health PE		Health PE		Health PE		Health PE		Health PE	
Visual Perf.Arts		Visual Perf.Arts		Visual Perf.Arts		Visual Perf.Arts		Visual Perf.Arts	
Practical Arts		Practical Arts		Practical Arts		Practical Arts		Practical Arts	
World Lang.		World Lang.		World Lang.		World Lang.		World Lang.	
Electives CCCS		Electives CCCS		Electives CCCS		Electives CCCS		Electives CCCS	

It's important to keep track of the courses that are required for graduation. Some schools have local requirements that must also be met, like community service.

I must pass the High School Proficiency Assessment as a requirement for graduation: YES ☐ NO ☐

I plan to go to college. I am taking College Prep courses (List below) YES ☐ NO ☐

I plan to work after high school. Vocational training I have taken: (List courses below) YES ☐ NO ☐

Lifelong Learning

Name _____
Age _____
Today's Date _____

How old will I be when I graduate?	18 _____	19 ____	20 _____	21	
Do I plan to go to college after I graduate?	Yes _____		No _____		
If Yes:					
What kind of school am I interested in?	University or College	Full time _____		Part time _____	
	Community College	Full time _____		Part time _____	
	Trade/Technical School	Full time _____		Part time _____	
	Adult Vocational School	Full time _____		Part time _____	
Will I need to take College Board exams (SAT)?		Yes _____		No _____	
Have I taken the SAT yet?		Yes _____		No _____	
I am taking College Prep Courses		Yes _____		Not yet _____	
I know what courses I need to take to apply to college		Yes _____		Not sure _____	
I know what disclosure means		Yes _____		No _____	
I plan to disclose my disability at college		Yes _____		No _____	
I know how to contact disability services in college		Yes _____		Not sure _____	
My evaluations are current		Yes _____		Not sure _____	

Your Case Manager and/or Guidance Counselor will be able to answer questions about important information that you may need to make these academic choices.

Workplace Readiness

Mark (×) the ones that make the most sense for you

I'm not going to college. . .
What are my plans?
What will help me prepare for work while I am in high school?

Employment	Full time _____	Part time _____
Job Tours	Yes _____	No _____
Job Shadowing	Yes _____	No _____
Job Sampling	Yes _____	No _____
Career Exploration	Yes _____	No _____
Structured Learning Experience	Yes _____	No _____
Supported Employment	Yes _____	No _____
Summer Jobs	Yes _____	No _____
Apprenticeships	Yes _____	No _____
Career Development Programs	Yes _____	No _____
Vocational School	Yes _____	No _____
In-School Work Experience	Yes _____	No _____
Tech Prep	Yes _____	No _____

Personal Reflection

These are my strengths:

This is what I need help with:

Other thoughts: