# Application

Form completed by ______________________ Relationship to individual ____________________

Date completed ________________

## Individual Information

Name ____________________________ ☐ M ☐ F Age ____ Birthdate ______________

Address __________________________ City ______________ State ______ Zip_________

Phone number______________________ Email______________________________________

Primary language ___________________ Race______________ Ethnicity ______________

Referred by _________________________ Is the individual registered to vote? Yes No

Does the individual have a legal guardian? Yes No

If yes, who is the legal guardian? _____________________________________________

## Parent/Guardian Information

Name(s)______________________________________________________________________

Address __________________________ City ______________ State ______ Zip_________

Phone number(s)_____________________ Email(s) _________________________________

_____________________ _________________________________

Primary language ____________________

Reason(s) seeking these services?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## Emergency Contact (other than parents/guardians)

Name _________________________________________________________________________

Address __________________________ City ______________ State ______ Zip_________

Phone number ______________________ Email ___________________________________

## Current Diagnoses and Concerns

Primary Diagnosis ______________________________ Age at time of Diagnosis ______________

Professional who made the diagnosis ____________________________________________________

Comorbid Diagnosis ______________________________ Age at time of Diagnosis ______________

Professional who made the diagnosis ____________________________________________________

Comorbid Diagnosis ______________________________ Age at time of Diagnosis ______________

Professional who made the diagnosis ____________________________________________________

Comorbid Diagnosis ______________________________ Age at time of Diagnosis ______________

Professional who made the diagnosis ____________________________________________________

Areas of current concern or struggle (check all that apply)

____ Aggression
____ Overactivity
____ Depression
____ Anxiety
____ Appetite/Food Selection
____ Motor Skills
____ Self-Injury
____ Inattentive
____ Muscle Tone
____ Sensory Integration
____ Explosive Temper
____ Sleep Problems
____ Self-Help Skills
____ Self-Stimming
____ Medications
____ Peer Relationships
____ Motivation
____ Other ______________

## Current Living Environment

Who does the individual live with (check all that apply)?

____ Lives Independently
____ Mother
____ Father
____ Group Home
____ Spouse/Life Partner
____ Stepmother
____ Stepfather
____ Other ______________
____ Peers/Roommates
____ Siblings
____ Step Siblings

## Medical History

| Date/ Age | Diagnosis/Illness | Now | Past | Family History |
|---|---|---|---|---|
| | Serious head injury | | | |
| | Loss of consciousness | | | |
| | Frequent Headaches/Migraines | | | |
| | Other serious injury | | | |
| | Sleep Problems | | | |
| | Neurological Problems | | | |
| | Seizures (type) | | | |
| | Asthma | | | |
| | Diabetes | | | |
| | Autism/PDD | | | |
| | ADHD | | | |
| | Learning Disability | | | |

| Date/ Age | Diagnosis/Illness | Now | Past | Family History |
|---|---|---|---|---|
| | Emotional Trauma | | | |
| | Oppositional defiant disorder | | | |
| | Anxiety disorder | | | |
| | Obsessive-compulsive disorder | | | |
| | Depression | | | |
| | Bipolar disorder | | | |
| | Schizophrenia | | | |
| | Tourette Syndrome | | | |
| | Eating disorder | | | |
| | Physical/Sexual Abuse | | | |
| | Dementia/Alzheimer's | | | |
| | Other: | | | |

**Hospitalizations, surgeries, and procedures (medical and behavioral)** ☐ No hospitalizations, surgeries, or procedures

| Reason for hospitalization/surgery/procedure | Age | Length of stay |
|---|---|---|
| | | |
| | | |
| | | |

**Allergies** (to medications, foods, environmental antigens, etc.) ☐ No past or current allergies

| Source (medication, food, etc.) | Nature of reaction (hives, trouble breathing, etc.) |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Current Medications** ☐ No current medications

| Medication | Date Started | Reason for Medication | Prescriber |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Discontinued Medications**

| Medication | Date Ended | Reason for Medication | Reason for Discontinuation |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Current Healthcare Providers**

| Specialty | Name | Phone |
|---|---|---|
| Primary Care Provider | | |
| Neurologist | | |
| Mental Health Provider | | |
| Medication Manager | | |
| Other: | | |
| Other: | | |

**Former Healthcare Providers**

| Specialty | Name | Phone |
|---|---|---|
| | | |
| | | |
| | | |

## Educational History

| | School Name | City | Earned (Check all that apply) | |
|---|---|---|---|---|
| High School | | | | HS Diploma |
| 18-21 yr. old Program | | | | GED |
| Vocational Training Center | | | | Certificate |
| College | | | | Associate degree |
| | | | | Bachelor's degree |
| | | | | Master's degree |
| Other: | | | | |
| Other: | | | | |

## Vocational History

| | Company | Job Title | Date Started | Date Ended | Weekly hours |
|---|---|---|---|---|---|
| Employer | | | | | |
| | | | | | |
| Job Training/ Supported Employment | | | | | |
| | | | | | |
| Volunteering | | | | | |
| | | | | | |

## Current/Former Services

| Service | Provider Name | Frequency | Current | Date Ended |
|---|---|---|---|---|
| Counseling | | | | |
| Speech Therapy | | | | |
| Occupational Therapy | | | | |
| Physical Therapy | | | | |
| Medical Treatments | | | | |
| Vocational Rehabilitation | | | | |
| WIOA | | | | |
| Targeted Case Management | | | | |
| Residential Supports | | | | |
| Day Services | | | | |
| In Home Care | | | | |
| SSI/SSDI | | | | |
| Other: | | | | |

## Additional Information