121 Cox Street * Benton, AR * 72015
501 776-0691 501 776-0692 fax

APPLICATION

Date: _____

Name: _____ Date of Birth: _____ Age:_____
Address: _____ Social Security # _____
_____ Phone: _____
County: _____ e-mail address: _____

Gender _____ Race _____ Marital Status: _____ DD# _____
Primary Language:_____ Legal Status:_____ Admission Date:_____

Primary Disability: _____
Secondary Disability:_____

Health Insurance: _____ Insurance Phone: _____
Insurance Number _____
Medicare Number _____ Medicaid Number _____

Primary Contact Person
Name: _____ Home phone _____ Relationship _____
Address: _____ Work phone _____
_____ Other Phone _____
e-mail address: _____

Emergency Contact Person
Name: _____ Home phone _____ Relationship _____
Address: _____ Work phone _____
_____ Other Phone _____

Secondary Contact Person
Name: _____ Home phone _____ Relationship _____
Address: _____ Work phone _____
_____ Other Phone _____

Emergency Contact Person #2
Name: _____ Home phone _____ Relationship _____
Address: _____ Work phone _____
_____ Other Phone _____

Person making the referral: (if different than primary contact)
Name: _____ Home phone _____ Relationship _____
Address: _____ Work phone _____
_____ Other Phone _____

Physician
Name: _____ Work phone _____ Medicaid # _____
Address: _____ Emergency phone _____
_____ Physician ID _____

	Medication Name	Dosage	Time taken	Prescribed for
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				

Medical Allergies/Restrictions: _____
Food Allergies/Restrictions: _____
Environment Allergies/Restrictions: _____
People Restrictions: _____
Other Medical Diagnoses: _____
_____

Childhood Diseases

(List the age and condition disease or injury occurred in the client)

Measles _____
German Measles _____
Chicken Pox _____
Whooping Cough _____
Mumps _____
Allergies _____
Throat Infection _____
Ear Infection _____
Fainting _____
Falls _____
Diabetes _____

Rheumatic Fever _____
Kidney Disease _____
Convulsions _____
Polio _____
Meningitis _____
Encephalitis _____
Tuberculosis _____
Congenital Defects _____
Headaches/migraines _____
Heart Disease _____

Operations: _____
_____
_____
Burns/Accidents _____
_____
_____
Other _____
_____

Sensory Functions

Vision _____ Normal _____ Abnormal
Smell _____ Normal _____ Abnormal
Feeling _____ Normal _____ Abnormal

Hearing _____ Normal _____ Abnormal
Taste _____ Normal _____ Abnormal

Therapy

(Speech Therapy, Physical Therapy, Occupational Therapy, etc…)

Does individual receive or has received therapy in the past? ☐ YES ☐ NO

If yes, what type of therapy, who provided it and when

TYPE OF THERAPY	PROVIDER	DATES RECEIVED

General Functioning Level of the Individual

1 Ambulation: How does the individual get around? Walks, needs assistance, uses cane, wheelchair, etc…

_____

2 Motor Coordination and Physical Dexterity: _____

_____

3 Self-Care Skills:

A. Dresses Self: (With or without assistance, not at all, ties shoes, buttons, zips, etc…)

_____

B. Feeds Self: (Uses knife, fork, spoon, finger feeds, with assistance, must be fed, special utensils)

_____

C. Toileting: (Independently, with assistance, not at all, day/night, on a schedule)

_____

D. Personal Grooming: (Brush teeth, comb hair, bathe self, shave, etc…)

_____

4 Communication Skills

A. Level of complexity: (Uses complex, verbal concepts, communicates in single sentences, uses a few words only, uses sounds/gestures, sign language, does not communicate)

_____

B. Level of articulation: (Understandable by strangers, somewhat hard to understand, no effective speech, jabbers, makes no sound) _____

Behaviors

Check any of the following which are problems and describe

	Difficult to discipline:
	Gets upset easily:
	Temper tantrums:
	Nail Biting:
	Thumb sucking:
	Sexual acting out:
	Difficulty sleeping:
	Nightmares:
	Bed wetting:
	Destructive:
	Prefers to be alone:
	Unusually active:
	Unusual difficulties with brothers/sisters:
	Unusual difficulties getting along with others
	Verbal or Physical Threats to harm self, others or property
	Wanders
	Afraid of anything

Cognitive Functioning

1 Academic Skills: (Reading, Writing, Arithmetic, Spelling)

_____

2 Survival Skills: _____

3 Everyday Living Skills: _____

Family History

Father's Name: _____ Birthdate: _____ Occupation: _____
Mother's Name Birthdate: Occupation:

Siblings:	Name	Birthdate	Relationship:	Lives in the home?
1				
2				
3				
4				
5				

Other significant people in client's life: _____

_____

_____

Family Health If any of the client's relatives have had any of the following conditions, please check the condition and write next to it the relationship to the client (brother, sister, parent, grandmother, uncle, etc…) and description.

	Disease/Condition	Family Member	Description
	Convulsions		
	Cerebral Palsy		
	Hearing Loss		
	Mental Retardation		
	Speech Problems		
	School Difficulties		
	Muscular Weakness		
	Deformities		
	Severe Visual Impairment		
	Alcoholism/Drug usage		
	Emotional Problems		
	Genetic Defects		
	Cancer		
	High Blood Pressure		
	Heart Trouble		
	Diabetes		
	Thyroid disorder		
	Other		

Education /Vocational History

List all schools and/or programs the client has attended, with complete addresses and dates of attendance

School/Program	Address	Dates Attended	Reason for leaving

Work History

Place of Employment	Address	Dates Employed	Reason for leaving

Psychological Information

Date of Exam	Verbal IQ	Performance IQ	Full Scale IQ	Type of Exam	Tested by

Diagnoses: _____

_____

Risk Factors: List any factors that may be a risk for for this individual or others including health issues, safety concerns, and challenging behaviors.

_____

_____

_____

Financial Information

Source of monthly income, amount and payee

	Type Social Security	Amount	Payee
	SSI		
	VA		
	Trust Fund		
	Other		

Special Interests

List any special interests, talents and skills below, including Special Olympics

_____

_____

_____

_____

_____

Other Information

List anything else that you feel would help us meet the needs of this client.

_____

_____

_____

_____

Person Completing this form: _____

Relationship to Applicant: _____

Telephone Number: _____

Date: _____