**Application for Services**

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| Name of Person Completing Form:  | Date: / /  |
| **Applicant Information** |
| Name of Client: |
| Address: |
| City: | State: | Zip: |
| Date of Birth: / /  | Ethnicity: | Gender: |
|  |  |  |
| **Parent/Guardian Information** |
| Parent/Guardian Name: | Relationship to Client: |
| Address: |
| City: | State: | Zip: |
| Home Phone Number: ( )  | Cell Phone Number: ( )  |
| Email Address: |
| Parent/Guardian Name: | Relationship to Client: |
| Address: |
| City: | State: | Zip: |
| Home Phone Number: ( )  | Cell Phone Number: ( )  |
| Email Address: |
|  |
| **Referral Source** |
| How did you hear about our services? |
| Referring Agency Name: |
| Contact Person Name: | Phone Number: ( )  |
| Address: |
| City: | State: | Zip: |
| Support Coordinator Name: | Phone Number: ( )  |
| Address: |
| City: | State: | Zip: |
|  |
| **Family Information** |
| Primary Language Spoken at Home: | Primary Language Spoken by Client: |
| Primary Form of Communication: |
| Does the client have any siblings? |
| If so, what are their names and ages? |
| Are there other people living in the home (family friends, extended family, etc.)? |
| Family Income Range: (please check)[ ] <$24,999 [ ] $25,000-49,999 [ ] $50,000-74,999 [ ] $75,000-99,999 [ ] $100,000+ |

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| **Educational History** |
| Day program/school/EI program name: |
| Address: |
| City: | State: | Zip: |
| Phone Number: ( )  |
| Class Type (please check):[ ] Self-contained [ ] Inclusion [ ]  Regular [ ]  Home-based Instruction [ ]  Home Schooled |
| Grade: | Date of Last IEP/IFSP: / /  |
|  |
| **Medical History** |
| Diagnosis: |
| When was the client diagnosed (date/age)? |
| Who made the diagnosis (name/title)? | Phone Number: ( )  |
| *Please forward a copy of the diagnostic report to the program.* |
|  |
| Primary Physician: | Phone Number: ( )  |
| Address: |
| City: | State: | Zip: |
| *Please forward a copy of the most recent physical examination and up-to-date immunization record.* |
|  |
| Speech Therapist: | Phone Number: ( )  |
| Occupational Therapist: | Phone Number: ( )  |
| In-Home Supports: | Phone Number: ( )  |
| Psychiatrist: | Phone Number: ( )  |
| Developmental Pediatrician: | Phone Number: ( )  |
| Other Therapy (name/type): | Phone Number: ( )  |
| Does the client have any medical concerns? |
| Does the client take medication regularly? If yes, please list the name, dosage, and times for all given medications: |
| Does the client have a history of seizures? |
| Does the client have any allergies? If yes, please list: |
| Does the client have any physical disabilities? If yes, please list: |
| **Behavioral History** |
| Does the client have any specific eating problems or mealtime behaviors? |
| Is the client toilet-trained? |
| Does the client have difficulty sleeping or other bedtime issues? |
| Does the client display any of the following behavior (please circle):Aggression Self-Injury Non-Compliance Destruction Inflexible Routines or Rituals Stereotypy(self-stimulatory behavior) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please describe what these behaviors look like for the client and how you respond: |

Is there anything else you would like us to know about the client?

**FOR OFFICE USE ONLY:**

Date Application Received: Received by:

Date of First Appointment: Therapist Assigned:

Notes: