Demo Therapeutic Program

Application for Enrollment

Submitted By: team@bestnotes.com

Client Information

Name:		Expect to Enroll:	
Gender:		Race:	
DOB:	Age:	Ethnicity:	
SSN:		Height:	Weight:
Address:		Eyes:	Hair:
City/State/Zip:		Shoes:	
Country:		Shirt:	Waist:
		School Grade:	
		Religious Pref:	

Emergency Contact (other than Parent/Gaurdian):

Relationship:		Address:	
Name:		City/State/Zip:	
Phone:			

Parent/Guardian/Sponsor Information

Parent/Guardian/Sponsor: (PRIMARY)

Relationship:		Preferred Contact Method:	
Name:		Sponsor:	
Address:		Legal Cust.:	
Home Phone:		Physical Cust.:	
Mobile Phone:		Emerg. Contact:	
Home Email:		Parent Guardian:	
Home Fax:		DOB:	
		SSN:	
		Job Title:	
		Employer:	
		Work Phone:	
		Work Email:	
		Work Fax:	
		Religious Pref:	

Briefly describe the relationship between this person and the child:

Referral Information

How did you first hear about Demo Therapeutic Program?

Please give the name(s) of the referral source including phone, fax number and email:

Reason for referral: Chief complaint and symptoms (please be very specific including issues at home and school as well as any symptoms noticed such as mood changes, etc.)

Family Information

Parents' current marital status:

If divorced or separated, please provide the date:

How do you believe the divorce/separation has affected your child? Please explain:

Describe the visitation arrangement:

Is your child adopted?
If adopted, at what age?
Important circumstances surrounding the adoption process or afterwards:
Number of siblings?
Please list Name, Age, Current Residence and Health of each sibling:
Where was your child born? (include city, state, country and physical location: hospital, home, etc.)
Were there any complications during birth mother's pregnancy or delivery?
If yes, please explain:

Educational Information

What is the highest grade your child has completed?
Currently attending school?
Name of Current School:
Does Demo Therapeutic Program have permission to contact the current school in relation to academics and interventions etc., about the applicant?
Name of Previous School:
Does Demo Therapeutic Program have permission to contact the previous school in relation to academics and interventions etc., about the applicant?
Is your child behind in credits?:
If yes, please explain:

Academic Strengths/Interests:

Favorite Subjects: (please check all that apply)

☐ Math	☐ English	☐ Science	☐ History
☐ Reading	☐ Computers	☐ P.E.	☐ Foreign Languages
☐ Music	☐ Choir	☐ Art	☐ Shop

Other:

Least Favorite Subjects: (please check all that apply)

☐ Math	☐ English	☐ Science	☐ History
☐ Reading	☐ Computers	☐ P.E.	☐ Foreign Languages
☐ Music	☐ Choir	☐ Art	☐ Shop

Other:

Sports/Extra-curricular Activities:
Athletics:
Academic:
Cultural:
Other:

Has your child ever been assessed for learning disabilities?
If yes, please describe:

Has your child received any medical or educational treatment for learning disabilities?
If yes, please describe:

If there have been no learning disability assessments, do you have concerns this may be an issue for your child?
If yes, please explain:

Does the applicant have an Individualized Education Plan (IEP) or 504, and/or a Behavior Intervention Plan (BIP)?
If yes, which one(s):

What interventions were in place for the applicant at school before they came to Demo Therapeutic Program at the time of this application?

School Information

Please include the name and location of each school attended:

Elementary: -
Student's Strengths:
Challenges:
Middle School: -
Student's Strengths:
Challenges:
High School: -
Student's Strengths:
Challenges:
Suspensions/Expulsions?
If yes, please give dates and reasons:

Academic/Intellectual Tests:
If yes, please describe all tests (include Name/Type of Test, Date Given, Contact Phone):

***Note:** Please fax/mail/e-mail a copy of these tests as part of your application.

Placement Information

What specific events precipitated your decision to seek treatment?

What are your specific goals for your child while receiving treatment?

What would you describe as your child's strengths (intellectually, artistically, socially, physically, etc.)?

What would you describe as your child's **weaknesses** (intellectually, artistically, socially, physically, etc.)?

Please describe your child's experience with the outdoors and other physical activities:

Do you have any plans for future placement?

Last known address of the child (address at time of admission):

Who is child living with:
Who is placing child in program:
Comments:

Placement/Intervention History

Please list all previous, relevant placements and/or interventions (including home therapists, psychiatrists, etc.):

Placement/Intervention 1:

Can we contact?
Location:
Dates:
Provider:
Reason for placement/intervention and outcomes:

Placement/Intervention 2:

Can we contact?

Location:

Dates:

Provider:

Reason for placement/intervention and outcomes:

Placement/Intervention 3:

Can we contact?

Location:

Dates:

Provider:

Reason for placement/intervention and outcomes:

Psychological Testing: Has your child had any psychological testing?
If yes, please describe (include date/reason):

***Note:** Please fax/e-mail/mail all previous testing from the last 3 years as part of this application

Ethnicity, race, religion, nationality, or sexual orientation. Please describe anything of note:

Psychological History

Please describe any **major events** your child has struggled with (divorce, moving, birth of sibling, loss, death, abuse, illness, etc.) Please include the date the event occurred:

Anger: Describe the way(s) in which your child expresses anger:

Has your child had any physical confrontations in the home or with others?
If yes, please describe:

Has your child ever intentionally hurt him/herself?
If yes, please describe (include date/reason):

Running Away: Has your child ever run away?
If yes, please describe (specify date, how long, where, contacted you?, etc.):

Suicidality: Has your child ever had thoughts of suicide, made a plan, or attempted suicide?
If yes, please describe (specify date/reason):

Sexual activity: Please describe any risky, aggressive or inappropriate sexual behaviors (promiscuity, unprotected sex, perpetrating, deviance, etc.):

Mood issues: Does your child exhibit signs of anxiety, depression, mood swings, etc.?
If yes, please describe:

Obsessions/Compulsions: Does your child experience recurrent thoughts or repeated behaviors that he/she cannot control?
If yes, please describe in detail including dates:

Lying, stealing, vandalism, dealing drugs, criminal activity:
If yes, please describe in detail including dates:

Unusual Behaviors: Check all that apply:

Please describe in detail including dates:

Eating issues (current or past):
If yes, please describe in detail including dates:

Isolation: Does your child isolate from others?
If yes, please describe in detail:

Substance-related issues: Does your child have any alcohol, substance and/or dependency related issues?
If yes, describe when you first noticed substance use and the choice of substance, usage patterns/frequency and how administered; please include cigarette use:

Family history of drug or alcohol abuse?
If yes, please describe (include who/relationship, problem area, current status):

Other addictive patterns (eg: computer games, T.V., phone, internet, sex, gambling):
If yes, please describe:

Legal Problems:
If yes, please list any charges, convictions, misdemeanors, felonies, probation and current legal status:

Family history of mental illness: (eg: depression, anxiety, etc.)
If yes, please describe (include who/relationship, problem area, current status):

Medical Information

Family Doctor:

Family Dentist:

Does your child wear:
Date of last physical:

Please list any surgeries, serious illness and/or hospitalizations. Please include date/event:

Please list any prescription and/or over-the-counter medications your child is currently taking and the reasons for each (include dosage, prescribing physician/phone):

Are there any known side effects of the medication?
If yes, please describe:

Please describe previous history of medications: (include name of medication, dosage, reason, prescribing physician)

Is your child currently taking any vitamins or supplements?
If yes, please describe:

Does your child currently get exercise?
If yes, please describe:

Describe any pertinent medical/physical information that might inhibit physical activity:

Does your child have any dietary restrictions?
If yes, please describe:

Does your child currently have or ever had any of the following? (check box if yes):

☐ Allergies	☐ Anaphylactic Shock	☐ Anemia	☐ Ankle problem
☐ Anorexia / bulimia	☐ Appendicitis	☐ Arm problem	☐ Arthritis
☐ Asthma	☐ Back problems	☐ Bedwetting	☐ Bladder / kidney problems / infections
☐ Bleeding Disorder	☐ Bone condition	☐ Bowel problems	☐ Broken bones

- [ ] Cancer
- [ ] Chest pains
- [ ] Chronic cough
- [ ] Circulation issues
- [ ] Colds-frequent
- [ ] Constipation
- [ ] Cysts / Tumors
- [ ] Dermatitis
- [ ] Diabetes I & II
- [ ] Diarrhea
- [ ] Difficulty walking or lifting
- [ ] Ear infections
- [ ] Endocrin problems
- [ ] Excessive sweating
- [ ] Fainting,dizziness
- [ ] Family history of heart disease
- [ ] Foot problem
- [ ] Frequent colds / sore throats
- [ ] Frequent heartburn
- [ ] Frequent muscle cramps
- [ ] Frequent shortness of breath
- [ ] Frostbite
- [ ] Gas / bloating
- [ ] Head traumas
- [ ] Headaches / migraines
- [ ] Hearing impairment
- [ ] Heart problems / murmurs
- [ ] Hepatitis A B C
- [ ] Hernia
- [ ] High blood pressure
- [ ] Hypoglycemia
- [ ] Intolerance to cold
- [ ] Intolerance to heat,overheats easily
- [ ] Irregular heartbeat
- [ ] Joint injuries
- [ ] Kidney problems
- [ ] Knee problem
- [ ] Leg problem
- [ ] Liver problems
- [ ] Lung infections
- [ ] Medical equipment or devices
- [ ] Meningitis
- [ ] Menstrual Problems / heavy bleeding
- [ ] Mononucleosis
- [ ] Motion sickness
- [ ] Obesity
- [ ] Other
- [ ] PMS - severe symptoms
- [ ] Pneumonia / bronchitis
- [ ] Pregnancy
- [ ] Recurrent injury/surgery
- [ ] Scoliosis
- [ ] Seizures, epilepsy
- [ ] Shoulder problem
- [ ] Skin diseases / problems
- [ ] Sleepwalking
- [ ] TB - Positive test
- [ ] TB - Recent exposure
- [ ] TB - Tuberculosis
- [ ] Thyroid problems
- [ ] Ulcers
- [ ] Unexpected weight loss
- [ ] Urination problem

Please describe in detail any checked items:

Immunizations: Is your child up-to-date on immunizations?
Date of last immunization:
Tetanus/Diphtheria:
Measles, Mumps, Rubella:
Hepatitis B:
Polio:

Allergies/asthma:
List all allergies (food, medication, grasses, etc.), how activated and what happens:

Does your child carry an inhaler or epinephrine pen?
Please list name/type of inhaler:

Has your child ever been hospitalized for allergies/asthma?
If yes, please describe (include date/reason):

Family Medical History: Please list any pertinent medical history in your child's family:

Insurance Information

Primary Insurance Company:

Address: , ,

Benefits Phone:

Group Number:

Policy Number:

Policyholder's Name:

Employer:

Date of Birth:

Social Security Number:

Secondary Insurance Company:

Address: , ,

Benefits Phone:

Group Number:

Policy Number:

Policyholder's Name:

Employer:

Date of Birth:

Social Security Number: