1515 Monrovia Ave., Newport Beach, CA 92663 • (714) 241-6214 • Fax: (714) 431-3602

ACQUIRED BRAIN INJURY PROGRAM APPLICATION

Applicant's name_____SS#_____

Address_____City_____Zip_____

Phone number _____Date of birth _____Age _____

Conservatorship? ☐ No ☐ Yes

Name_____

(If yes, please provide legal documentation)

The following application is to be completed by the potential student. If completed by someone other than the student, please explain: _____

_____

Name of person completing the application? _____

Relationship to prospective student _____

MEDICAL HISTORY

Date of trauma _____ Age at time of trauma _____

If in coma, how long did it last? _____

Briefly describe conditions surrounding trauma experience/accident _____

_____

_____

_____

_____

What means of transportation will you use in getting to classes?

☐ Drive self ☐ Family/friend ☐ Bicycle

☐ Walk ☐ Public transportation ☐ Other _____

EDUCATIONAL HISTORY PRIOR TO TRAUMA

High school attended _____

Date of graduation _____Circle last grade completed: 9 10 11 12 13 14 AA BA MA PhD

Education after high school graduation_____

_____

MEDICAL CARE RECEIVED AFTER TRAUMA

Hospital	City	Physician	Dates (inclusive)

CONVALESCENT CARE FOLLOWING HOSPITAL

SiteCity	Contact	Person	Dates (inclusive)

REHABILITATION THERAPY (Physical, Speech, Occupational, etc.)

Site	City	Contact Person	Dates (inclusive)

PSYCHIATRIC CARE (Counseling, Psychotherapy, etc.)

(Include pre- and post-trauma care)

Site	City	Contact Person	Dates (inclusive)

EDUCATION SINCE TRAUMA (Including Vocational Rehabilitation)

Site	City	Contact Person	Dates (inclusive)

At present, what services are you receiving? _____

_____

_____

WORK HISTORY PRIOR TO TRAUMA

Employer	City	Position held	Dates (inclusive)

WORK HISTORY SINCE TRAUMA

Employer	City	Position held	Dates (inclusive)

Vocational goal _____

CURRENT MEDICAL DATA

Present physician _____

Address _____City_____ Zip _____

Phone _____

Present medications _____

_____

Possible side effects of medications _____

_____

Present medical problems _____

Do you suffer from: ☐ Hearing impairment; if so, degree _____

Do you suffer from: ☐ Visual impairment; if so, degree _____

☐ Paralysis; if so, degree_____

☐ Incontinence

Do you use: ☐ Wheelchair ☐ Quadcane ☐ Cane ☐ Walker

If yes to any of the above, can you use restroom facilities unaided? ☐ Yes ☐ No

Have you ever had a seizure? ☐ Yes ☐ No If yes, what was the date of your last seizure? _____

How many seizures have you had in the past twelve months? _____

List allergies _____

Have you ever been treated for alcoholism or drug abuse? ☐ Yes ☐ No

If yes, what treatment _____ When _____

Have you ever been arrested for anything other than a misdemeanor? ☐ Yes ☐ No

If yes, what charge _____

When _____Disposition _____

Are you on probation? ☐ Yes ☐ No

Have you ever been on probation? ☐ Yes ☐ No Date _____

OTHER SERVICES

Are you presently a client of the Department of Rehabilitation? ☐ Yes ☐ No

If yes, give address _____

_____ Phone _____

Counselor _____

Are you currently receiving benefits from: ☐ AFDC/TANF ☐ General Assistance ☐ SSI/SSP

GENERAL

What are your current activities (work, leisure, etc.) _____

What do you consider to be the major problems as a result of your accident?

General: _____

Educational: _____

Vocational: _____

Social: _____

Personal: _____

Other problems related to social, educational, financial or vocational problems: _____

What do you hope to gain from attending the ABI Program? _____

_____

_____

ABI classes meet from 8:30 a.m. to 12:30 p.m., Monday through Thursday. If you are accepted into the program, would you be willing and able to participate fully in this schedule? ☐ Yes ☐ No
If no, please explain: _____

_____

_____

Family support and involvement are an important part of the ABI Program. May we have your permission to include your parent(s), guardian, spouse, and/or significant other in meetings regarding your individual program and to share your records with that individual? ☐ Yes ☐ No

If yes, please identify the individual(s) you wish to have included:
Name _____ Relationship to you _____
Address _____ City _____ Zip _____
Phone number (home) _____ (business) _____

Name _____ Relationship to you _____
Address _____ City _____ Zip _____
Phone number (home) _____ (business) _____

I hereby declare the statements and answers in this application are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application and I hereby release from all liability any person(s) or organization(s) furnishing such information. I understand that falsification, misrepresentation, or omission of the facts is cause for rejection of the application, removal of my name from consideration or dismissal from the ABI Program.

_____

Parent or Guardian's signature (If applicant is under 18 years of age or legal ward) Date

_____

Applicant's signature Date