arbi making life better
Association for the Rehabilitation of the Brain Injured

CLIENT APPLICATION FORM

DATE: ______________________________

NAME OF CLIENT: ____

PRESENT PLACE OF RESIDENCE: ____

HOME ADDRESS: ____

CITY: _________________________ PROVINCE: ___________________ POSTAL CODE: __________________

PHONE: (____) ________________________ MARITAL STATUS: _________________________________

DATE OF BIRTH: ___________________SEX: ______ PROV. HEALTH CARE #___________________________

FUNDING: _______________________ AISH: ______________ WCB: __________________

HANDI-BUS: _______________________ DATE OF REFERRAL: ____________________________

CONTACT PERSON: ______________________________________ RELATIONSHIP: ______________________

ADDRESS: ___________________________________ EMAIL: ____

CITY: _______________________ PROVINCE: __________________ POSTAL CODE: ______________________

PHONE: (____) ________________________ BUSINESS PHONE: (____) ________________________________

THERAPISTS: ________________________________ PHONE: (____) _________________________________

PHYSICIAN: _________________________________ PHONE: (____) _________________________________

DATE OF INJURY OR ONSET: _____________________ LENGTH OF TIME IN COMA: ______________________

DIAGNOSIS: ____

THERAPIES RECEIVED PRESENTLY & PREVIOUSLY: ____
____

EDUCATION: ____

EMPLOYMENT HISTORY: ____
____

FAMILY MEMBERS & SUPPORT: ____
____

	YES	NO	COMMENTS
Do you think this person sees as well as before?			
Can or does this person:			
1. Gesture or point			
2. Use facial expression (if yes, provide example)			
3. Make noises			
4. Indicate yes/no (if yes, explain how)			
5. Talk			
6. Use other means of communication (i.e. electronic device, alphabet board, etc.)			
7. Wear any splints			
8. Have any movement in right hand			
9. Have any movement in left hand			
10. Have any joints that do not move freely			
11. Follow one step commands (i.e. give me the ball)			
12. Hold and release objects from right hand			
13. Hold and release objects from left hand			
14. Touch the top of own head with right hand			
15. Touch the top of own head with left hand			
16. Feed self			
17. Put on own shirt			
18. Add 23 + 36 =			
19. Tell you the names of 5 cities			
20. Know what year it is			
21. Look toward sounds/voice			
22. Look you in the eye when talking			
23. Have any behavioural problems			

	YES	NO	COMMENTS
24. Sensitive to touch? (during dressing, oral care)			
If yes, where?			
25. Cooperative? (if no, provide example)			
26. Show emotion? (if yes, provide examples)			
Anger			
Happiness			
Sadness			
Fear			
27. Use wheelchair			
28. Propel wheelchair by self			
29. Roll over by self			
30. Sit without support			
31. Transfer from bed to chair using:			
Mechanical lift			
One person assisting			
No help			
32. Stand: With support			
Alone			
33. Walk: With support			
Alone			
34. What type of stimulus holds their interest?			
Visual (e.g. people, TV, objects)			
Sound (e.g. voice, TV, radio)			
Touch (e.g. soft or rough fabric)			
Smell (e.g. pleasant or unpleasant)			

Presently, I participate ____ times/week in the community. (Please consider the number of times you are getting out of your place of residence (e.g. going shopping, visiting a friend, attending church or community group activity etc.) Please provide examples of your community outings:

____

____

____

Additional Comments:

____

____

____

Form Completed By: ____
(Please print name)

Signature: ______________________________ Date: ______________________________