

A NEW LEAF, INC.
Adult DT Application for Services



Date: _____

Client's Personal Information:

Name: _____

Address: _____

Mailing (If Different): _____

Email Address _____

Major intersections near home: _____

Date of Birth: _____ Age: _____ Gender: _____

Social Security #: _____ Medicaid#: _____

Targeted Service Coordinator: _____ Phone: _____

Parents: _____ Phone: _____

Guardian: _____ Phone: _____

Address (If different.): _____

Emergency Contact: _____ Phone: _____

Current Living Situation: _____

School: _____ Grade: _____ Teacher: _____

Please List Current Developmental Agencies/Therapies: _____

Please List Any Past Developmental Agencies/Therapies: _____

Professionals:

Physician:	Phone:
Specialist:	Phone:
Counselor:	Phone:
Therapist::	Phone:
Dentist:	Phone:
Optometrist:	Phone:
Audiologist:	Phone:
Other:	Phone:
Other:	Phone:

Medical Information:

Primary Diagnosis: _____ Secondary Diagnosis: _____

Current Medications: _____

Seizure Disorder: YES/NO Type: _____ Frequency: _____

Known Allergies/Special Diet: _____

Assistive Devices: _____

Communicable Disease: YES/NO If Yes, What? _____

Please list any other medical concerns: _____

Behavioral Information:

Please check any current behaviors:

Verbally Assaultive	Stealing	Screaming
Physically Assaultive	PICA	Obsessive Compulsive
Self-Injurious	Property Destruction	Defiance
Lying	Sexual Misconduct	Other:

Please check any past behaviors:

Verbally Assaultive	Stealing	Screaming
Physically Assaultive	PICA	Obsessive Compulsive
Self-Injurious	Property Destruction	Defiance
Lying	Sexual Misconduct	Other:

Requested Services:

_____ Individual Developmental Therapy
_____ Center _____ Home _____ Community
_____ Group Developmental Therapy
_____ Center _____ Community

Requested Days and Hours for Services:

Monday:	Thursday:
Tuesday:	Friday:
Wednesday:	Saturday:

Total Number of Hours Requested Per Week (30 maximum): _____

Requested Start Date: _____

Please give a short description of your major areas of concern, goals, and potential outcomes you would like to see through developmental services:

Participant Signature: _____ Date: _____

Guardian Signature: _____ Date: _____