PAPER AIRPLANE
behavioral services

New Client Application

CLIENT INFORMATION

Child's Legal Name _____ Nickname_____Sex _____
Date of Birth _____ Age __y ____mos. SSN _____
Primary Residence of Child _____City/State _____Zip_____
Home Phone Number_____
Insurance Carrier _____ Phone_____
Member Name _____ Member ID_____

PARENT/GUARDIAN INFORMATION

1st Guardian's Name_____ Home Phone_____
Relationship _____ Email Address _____ Cell Phone_____
Address (if different from child) _____
Employer _____Title _____Work Phone_____

2nd Guardian's Name_____ Home Phone_____
Relationship _____ Email Address _____ Cell Phone_____
Address (if different from child) _____
Employer _____Title _____Work Phone_____

Are there circumstances about the custody of your child that we should know about, which limit the sharing of records, picking up of your child, etc? ___Yes ___No (It is the parent's/guardian's responsibility to keep Paper Airplane Behavioral Services, PA informed of changes in custody by providing current and complete legal documents each year and after any changes.)

ADDITIONAL AUTHORIZED CAREGIVERS AND EMERGENCY CONTACTS

Please list the name, relationship, and phone number for ALL individuals who will be directly involved in your child's treatment and/or responsible during home sessions (e.g., babysitter/nanny, grandparents, other caregivers). Basic treatment information and/or session feedback may be provided to these individuals unless otherwise specified. This list may also be used in the event there is illness/event warranting parent/guardian contact if the parents/guardians cannot be reached in a reasonable amount of time.

Name	Relationship	Phone Number	
			☐Emergency Contact ONLY ☐OK to provide feedback
			☐Emergency Contact ONLY ☐OK to provide feedback
			☐Emergency Contact ONLY ☐OK to provide feedback
			☐Emergency Contact ONLY ☐OK to provide feedback

Preferred Hospital (in case of emergency) _____
Address_____ Phone_____

REFERRING INFORMATION/PRESENTING CONCERNS

Who referred you to Paper Airplane Behavioral Services, P.A.? _____
Reason for Referral/Presenting Concerns

MEDICAL INFORMATION HISTORY

Current Physician(s)/Health Care Provider(s):
Physician's Name_____Name of Practice/Clinic_____
Care Provided _____ Phone _____
Address _____

Physician's Name_____Name of Practice/Clinic_____
Care Provided _____ Phone _____
Address _____

Mental Health Provider Name_____Name of Practice/Clinic_____
Care Provided _____ Phone _____
Address _____

Mental Health Provider Name_____Name of Practice/Clinic_____
Care Provided _____ Phone _____
Address _____

List any assessments previously completed

Medical History
Has your child had any injuries/surgeries/major illness in past 6 to 12 months (If yes, provide a description and date)

Does your child have a history of seizures? (If yes, specify name and dosage of any prescribed medication)

Does your child have an insect, drug or Latex allergy? (If yes, please describe)

Please specify any dietary needs:
❒ Vegetarian ❒ No milk/dairy ❒ Soy ❒ Casein ❒ Whey ❒ Other (List)

Does your child have any past or current diagnoses?

Diagnosis	Diagnosing Provider	When Diagnosed

*Please include a copy of any psychological evaluation and/or diagnostic reports

Is your child currently prescribed any medications to address behavioral/psychiatric concerns?

Medication and Dosage	Prescribed for	Prescribed by

Please check YES or NO for the following health information concerning your child. Be sure to include any recent (past 6--12 months) injuries, illnesses, or surgery that is in the his/her health history which could influence participation in activities or other needs.

Arthritis/joint or bone condition ☐ Yes ☐ No _____

Asthma/Reactive Airway Disease ☐ Yes ☐ No _____

If yes, does your child carry an inhaler? ❒ Yes ❒ No

Bleeding/blood disorder (eg: anemia, hemophilia, sickle cell disease, etc.) ☐ Yes ☐ No _____

Developmental condition/consideration ☐ Yes ☐ No _____

Diabetes ☐ Yes ☐ No _____

Digestive/stomach condition ☐ Yes ☐ No _____

Dental/orthodontic appliance or other prosthesis ☐ Yes ☐ No _____

Eyeglasses/contacts/vision loss ☐ Yes ☐ No _____

Fainting/lightheaded episodes/heat sensitivity ☐ Yes ☐ No _____

Hearing loss ☐ Yes ☐ No _____

Heart condition or chest pain with exercise ☐ Yes ☐ No _____

High blood pressure ☐ Yes ☐ No _____

Seizure disorder ☐ Yes ☐ No _____

Immune system disorder (eg: mono, chronic fatigue syndrome, chemotherapy, etc.) ☐ Yes ☐ No _____

Menstrual disorder/difficulties ☐ Yes ☐ No _____

Significant fears/phobias ☐ Yes ☐ No _____

Sleep issues (eg: refusal, sleepwalking, snoring, daytime sleeping) ☐ Yes ☐ No _____

Toileting considerations ☐ Yes ☐ No _____

Orthopedic condition, recent injury, back pain ☐ Yes ☐ No _____

Other (please specify below) ☐ Yes ☐ No _____

FAMILY/SOCIAL HISTORY

Please list all caregivers and provide requested information.

Name	Age	Relationship to Child	Time Spent with	Education Level	Known Diagnoses/ History of Behavioral Concerns?

Please list all siblings and describe your child's relationship with each.

Name	Age	Relationship with Child	Lives at Home	School/Grade	Known Diagnoses/ Behavioral Concerns?
			Y / N		
			Y / N		
			Y / N		
			Y / N		
			Y / N		

Please list any other individuals who are living within the home (aunts, uncles, grandparents, etc.)

Name	Relationship to Child	Phone Number

Did/Does any one in your family have a diagnosis or challenge similar to your child? ___Yes ___No
If so, what is the individual's relation to your child? What are the similarities in diagnosis or challenge?

EDUCATIONAL HISTORY

School Name _____ Current Grade _____ Current Teacher _____
Phone _____ Contact Person (Name and Title) _____
Address (Include County) _____

Type of Class (seclusion, incision, blended, mainstream)_____ Ratio _____
Years Retained (if any) _____ Current Grades _____
Current IEP: ___Yes ___No

Describe any of the following opportunities or accommodations your child has in school.
Pull-Out/Resource Room or Specialized Small Group Instruction:

Opportunities for Inclusion/Participation in General Education:

Other Relevant Accommodations:

Services Provided by School	How Frequently	Session Length	Individual/Group?

Describe any concerns that you have or that have been reported to you specific to the school setting.

Do these concerns require immediate attention?

AS PARENT/GUARDIAN OF THE ABOVE, I VERIFY THAT THE INFORMATION PROVIDED IN THIS DOCUMENT IS CURRENT AND UNDERSTAND THAT I AM RESPONSIBLE FOR PROVIDING ANY UPDATES OR CHANGES TO THE INFORMATION TO PAPER AIRPLANE BEHAVIORAL SERVICES, P.A.

Signature of parent/guardian_____ Date_____

Print name_____