



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_____