General Application

(Please note that all information will be considered confidential)

Program Date: _____

Alternate Date: _____

GENERAL INFORMATION

Name of Applicant: _____

Address: _____

Street

_____

City *Province/State* *Postal Code/Zip*

E-mail: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Date of Birth: _____ Sex: *M* ___ *F* ___

M D Y

PERSONAL INFORMATION

Do you live alone? *Yes* ____ *No* ____

If no, with whom do you live? (name & relationship)

_____

Do you have children? *Yes* ____ *No* ____

If yes, provide names and ages:

_____ _____ _____

_____ _____ _____

Do you have grandchildren? *Yes* ____ *No* ____

If yes, provide names and ages:

_____ _____ _____

_____ _____ _____

Provide the names of people with whom you communicate on a regular basis:

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

MEDICAL HISTORY

What was the cause of your communication problem?

Stroke ____ Accident ____ Other (please describe) ____

Date _____ _____

Do you have any physical weakness or paralysis as a result of your illness/accident?

Yes ____ No ____ If yes, describe _____

Were you right or left handed before the present problem? *Right ____ Left ____*

Do you have any swallowing problems as a result of your illness/accident?

Yes ____ No ____ If yes, describe _____

Do you have any longstanding health conditions/problems?

Yes ____ No ____ If yes, describe _____

Please list any medications & dosages you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

COMMUNICATION HISTORY

Did you have any speech or hearing problems before your stroke/accident/illness?

Yes ____ No ____ If yes, describe _____

Is there any history of speech, language or hearing problems in your family?

Yes ____ No ____

If yes, name your relationship to the person and describe the problem:

_____

_____

_____

HEALTH AND PERSONAL CARE

Are you on any special diet?

Yes ____ No ____ If yes, describe _____

Do you have any allergies?

Yes ____ No ____ If yes, what are they? _____

Are you independent for all transfers? *Yes* ____ *No* ____

If no, describe _____

Are you ambulatory? *Yes* ____ *No* ____

If yes, how far can you go independently?

____ 25 meters or less ____ 25-100 meters ____ 100 meters or more

Do you regularly use a wheelchair? *Yes* ____ *No* ____

If yes, do you do so independently? *Yes* ____ *No* ____

Do you have special transportation requirements? *Yes* ____ *No* ____

If yes, describe _____

Do you wear glasses? *Yes* ____ *No* ____

If yes, why do you wear glasses? *reading*____ *distance*____ *both*_____

Describe any other visual difficulties that you have

Have you had your hearing tested? *Yes* ____ *No* ____ **When?** _____

Do you wear a hearing aid? *Yes* ____ *No* ____

If yes, for how long have you worn the aid? _____

EMPLOYMENT HISTORY

Occupation _____ **Workplace** _____

Past Occupations

Were you employed at the time of your stroke/accident/illness? *Yes* ___ *No* ___

Are you on a leave of absence? *Yes* ___ *No* ___ **How long?** _____

Are you retired? *Yes* ___ *No* ___ **How long?** _____

Are you retired due to your stroke/accident/illness? *Yes* ___ *No* ___

EDUCATIONAL HISTORY

What was highest grade level you completed in school? _____

Did you attend university/college? *Yes* ___ *No* ___

School Name _____ **Degree** _____

Is English your first language? *Yes* ___ *No* ___

Were you ever fluent in any other language(s)? *Yes* ___ *No* ___

If yes, what languages? _____

LEISURE TIME

Do you consider yourself an active person (you enjoy conversation and participating in activities with others)? *Yes* ___ *No* ___

What do you do in an average day?

_____

_____

_____

Please provide information about health services which you received or are currently receiving. Please ensure that contact information is current.

List hospitals/rehabilitation centers where you were a patient:

1. _____ approx. dates _____
2. _____ approx. dates _____
3. _____ approx. dates _____

Have you had any of the following tests?

CT scan- *Yes* ___ *No* ___ *If Yes,* Hospital name: _____

MRI - *Yes* ___ *No* ___ Hospital name: _____

EEG - *Yes* ___ *No* ___ Hospital name: _____

PET scan- *Yes* ___ *No* ___ Hospital name: _____

SPEECH-LANGUAGE ASSESSMENT/THERAPY

Dates _____

Clinician _____

Facility _____

Address _____

Street

_____

City *Province/State* *Postal Code/Zip*

Phone (_____)_____ E-mail _____

PHYSIOTHERAPY

Dates _____

Clinician _____

Facility _____

Address _____

Street

_____

City *Province/State* *Postal Code/Zip*

Phone (_____)_____ E-mail _____

OCCUPATIONAL THERAPY

Dates _____

Clinician _____

Facility _____

Address _____

Street

_____

City *Province/State* *Postal Code/Zip*

Phone (_____)_____ E-mail _____

PSYCHOLOGY /COUNSELING/SOCIAL WORK

Dates _____

Clinician _____

Facility _____

Address _____

Street

_____

City *Province/State* *Postal Code/Zip*

Phone (_____)_____ E-mail _____

RECREATION/LEISURE THERAPY

Dates _____

Clinician _____

Facility _____

Address _____

Street

_____

City *Province/State* *Postal Code/Zip*

Phone (_____)_____ E-mail _____

OTHER HEALTH CARE

Dates _____

Clinician _____

Facility _____

Address _____

Street

_____

City *Province/State* *Postal Code/Zip*

Phone (_____)_____ E-mail _____

Were you (the applicant) able to complete this form independently or did you require assistance? _____ If you required assistance, describe:

_____

_____

_____ /17