



2990 Mesa Verde Drive East, Costa Mesa, CA 92626 • (714) 241-6214

ACQUIRED BRAIN INJURY PROGRAM APPLICATION

If completed by someone other than the student, who is completing the application?

Name _____ Relationship to prospective student _____

The following application is to be completed by the potential student. If the student is unable to complete the application, please explain: _____

Applicant's name _____ SS# _____

Address _____ City _____ Zip _____

Phone number (____) _____ Date of birth _____ Age _____

Conservatorship? No Yes Name _____

MEDICAL HISTORY

Date of trauma _____ Age at time of trauma _____

If in coma, how long did it last? _____

Briefly describe conditions surrounding trauma experience/accident _____

What means of transportation will you use in getting to classes?

- Drive self Family/friend Bicycle
 Walk Public transportation Other _____

EDUCATIONAL HISTORY PRIOR TO TRAUMA

High school attended _____

Date of graduation _____ Circle last grade completed: 9 10 11 12 13 14 AA BA MA PhD

Education after high school graduation _____

MEDICAL CARE RECEIVED AFTER TRAUMA

Hospital	City	Physician	Dates <i>(inclusive)</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CONVALESCENT CARE FOLLOWING HOSPITAL

Site	City	Contact person	Dates <i>(inclusive)</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REHABILITATION THERAPY (Physical, Speech, Occupational, etc.)

Site	City	Contact person	Dates <i>(inclusive)</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PSYCHIATRIC CARE (Counseling, Psychotherapy, etc.)

(Include pre- and post-trauma care)

Site	City	Contact person	Dates <i>(inclusive)</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EDUCATION SINCE TRAUMA (Including Vocational Rehabilitation)

Site	City	Contact person	Dates <i>(inclusive)</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

At present, what services are you receiving? _____

WORK HISTORY PRIOR TO TRAUMA

Employer	City	Position held	Dates <i>(inclusive)</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

WORK HISTORY SINCE TRAUMA

Employer	City	Position held	Dates (inclusive)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Vocation goal _____

CURRENT MEDICAL DATA

Present physician _____

Address _____ City _____ Zip _____

Phone _____

Present medications _____

Possible side effects of medications _____

Present medical problems _____

Do you suffer from: Hearing impairment; if so, degree _____

Visual impairment; if so, degree _____

Paralysis; if so, degree _____

Incontinence

Do you use: Wheelchair Quadcane Cane Walker

If yes to any of the above, can you use restroom facilities unaided? Yes No

Have you ever had a seizure? Yes No If yes, what was the date of your last seizure? _____

How many seizures have you had in the past twelve months: _____

List allergies _____

Have you ever been treated for alcoholism or drug abuse? Yes No

If yes, what treatment _____ When _____

Have you ever been arrested for anything other than a misdemeanor? Yes No

If yes, what charge _____

When _____ Disposition _____

Are you on probation? Yes No Have you ever been on probation? Yes No Date _____

OTHER SERVICES

Are you presently the client of Department of Rehab? Yes No

If yes, give address _____

Phone () _____

Counselor _____

Are you currently receiving benefits from: AFDC/TANF General Assistance SSI/SSP

GENERAL

What are your current activities (work, leisure, etc.) _____

What do you consider to be the major problems as a result of your accident?

General: _____

Educational: _____

Vocational: _____

Social: _____

Personal: _____

Other problems related to social, educational, financial or vocational problems: _____

What do you hope to get out of attending the ABI Program? _____

ABI classes meet from 8:30 a.m. to 12:30 p.m., Monday through Thursday. If you are accepted into the program, would you be willing and able to participate fully in this schedule? Yes No If no, please explain:

Family support and involvement are an important part of the ABI Program. May we have your permission to include your parent(s), guardian, spouse, and/or significant other in meetings regarding your individual program and to share your records with that individual? Yes No

If yes, please identify the individual(s) you wish to have included:

Name _____ Relationship to you _____
Address _____ City _____ Zip _____
Phone number (home) (____) _____ (business) (____) _____

Name _____ Relationship to you _____
Address _____ City _____ Zip _____
Phone number (home) (____) _____ (business) (____) _____

I hereby declare the statements and answers in this application are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application and I hereby release from all liability any person(s) or organization(s) furnishing such information. I understand that falsification, misrepresentation, or omission of the facts is cause for rejection of the application, removal of my name from consideration or dismissal from the ABI Program.

Parent or Guardian's signature (If applicant is under 18 years of age or legal ward)

Date

Applicant's signature

Date