ConnectingPoint
OF PARK CITIES

# Client Application

Because each applicant is unique, CPPC needs to learn how to best serve and care for all of our clients. All of the applicant's information provided in this form is confidential and will be treated appropriately.

Please fill out the form thoroughly and return to us upon completion, there is a $100.00 application fee. We will evaluate the completed application when it is received and contact you with appropriate information as soon as possible. Thank you for your interest in Connecting Point of Park Cities.

Please return the application and payment to:

CPPC
4516 Lovers Lane, #212
Dallas, Texas 75225

Please make the check payable to "Connecting Point of Park Cities"

# Applicant's Personal Information

Full Name:_____

Primary Residence: Street Address _____

City _____ State _____ Zip _____

Guardian's Phone Number:_____

Alternate Phone Number:_____

Guardian's E-mail:_____

Applicant's Birth Date:_____/_____/_____ Sex: ☐ *male* ☐ *female*

Social Security Number:_____-_____-_____ Height:_____ Weight:_____

# Guardian Information

## Father's Information

Full Name:_____

Primary Residence: Street Address _____

City _____ State _____ Zip _____

E-mail:_____ Cell Phone:_____

Occupation:_____ Business Phone:_____

## Mother's Information

Full Name:_____

Primary Residence: Street Address _____

City _____ State _____ Zip _____

E-mail: _____ Cell Phone: _____

Occupation: _____ Business Phone: _____

Guardian's Information (if not parent)

Full Name: _____

Primary Residence: Street Address _____

City _____ State _____ Zip _____

E-mail: _____ Cell Phone: _____

Occupation: _____ Business Phone: _____

# Attendance

CPPC will offer programs Monday – Friday, from 9:00 a.m. - 2:30 p.m.

Days of the week Applicant will attend CPPC. Please list number and if actual day(s), please note that as well. For example: 3 days a week: Monday, Wednesday, Friday.

---

# Social History

Programs the Applicant Has Participated In:

- ☐ Public School
- ☐ Private School
- ☐ Group Home

☐ Independent Living
☐ Special Needs Class or Workshop
☐ Employment

## References

Please provide three references who can accurately discuss the character and condition of the applicant. If possible, reference people involved in programs that the applicant has participated in (see above). Otherwise, briefly describe the reference's relationship with the applicant in the space provided.

### Reference 1

Full Name:_____

Primary Residence: Street Address _____

City _____ State _____ Zip _____

E-mail:_____ Cell Phone:_____

Occupation:_____ Business Phone:_____

Relationship to the Applicant (i.e. teacher, mentor):

_____

_____

### Reference 2

Full Name:_____

Primary Residence: Street Address _____

City _____ State _____ Zip _____

E-mail:_____ Cell Phone:_____

Occupation:_____ Business Phone:_____

Relationship to the Applicant (i.e. teacher, mentor):

## Reference 3

Full Name:_____

Primary Residence: Street Address _____

City _____ State _____ Zip _____

E-mail:_____ Cell Phone:_____

Occupation:_____ Business Phone:_____

Relationship to the Applicant (i.e. teacher, mentor):

Please use the following prompts and questions to provide us with a better understanding of the applicant and his/her characteristics and abilities. Feel free to use the back of the form if additional space is needed.

Please describe the applicant's ability to communicate with others. Does he/she use communication aides of any sort?

Does the applicant prefer to be in a group or alone? Does he/she work better with someone older or with someone of the same age?

Discuss the general emotional state of the applicant. Is he/she easily aggravated, reserved, or hyper-verbal? Are there particular techniques or exercises that you use to cope with these emotions?

What is the applicant's ability to help him/herself? With what routine daily tasks does he/she need another's help?

What are the applicant's aptitudes and strengths? What are his/her greatest interests?

Please describe what you see as the applicant's disabilities.

Are you or the client receiving government aid? If yes, please describe briefly.

What does the applicant perceive his/her disabilities to be?

Briefly give a synopsis of the applicant's daily routine.

What are the activities that the applicant enjoys most?

What activities, situations, or things does the applicant strongly dislike?

What are your hopes and goals for the applicant during his/her time with CPPC? Are there any milestones you would like to see the applicant reach with CPPC?

# Medical History

## Preferred Hospital (In Case of Emergency)

Name:_____

Address: Street Address _____

City _____ State _____ Zip _____

## Physician Information

Full Name:_____

Address: Street Address _____

City _____ State _____ Zip _____

E-mail:_____ Business Phone:_____

Please list any other physicians that are treating or have treated the applicant in the last five years.

## Allergy Information

Is the applicant on any regular medications? ☐ *Yes* *No* ☐

If so, please fill out the following table accordingly.

| Medication | Dosage and Frequency | Prescribed By | Date Prescribed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please list any medications the applicant is allergic to:

_____

_____

_____

_____

List any other allergies the applicant has along with their typical reaction and necessary treatment.

_____

_____

_____

_____

Please list any dietary restrictions the applicant has.

_____

_____

_____

_____

# History of Hospitalization

Has the applicant been hospitalized in the last two years? ☐ *Yes* *No* ☐

If so, what was the attending physician's name?_____

Please describe the situation.

# Health History

If the applicant currently has or has had serious problems with any of the following issues, indicate below.

| Issue | *Place check if applicable* | Issue | *Place check if applicable* |
|---|---|---|---|
| Cold/Sinus Trouble | ☐ | Kidney Disease | ☐ |
| Headaches | ☐ | Stomach Trouble | ☐ |
| Eyes | ☐ | Diabetes | ☐ |
| Glasses | ☐ | Diarrhea or Constipation | ☐ |
| Ears | ☐ | Incontinence | ☐ |
| Hearing | ☐ | Fainting Spells | ☐ |
| Chest Infections | ☐ | Menstrual Problems | ☐ |
| Asthma | ☐ | Muscle Problems | ☐ |
| Epilepsy/Seizures | ☐ | Neurological Problems | ☐ |
| Tuberculosis | ☐ | Emotional Problems | ☐ |
| Heart Trouble | ☐ | Psychological Problems | ☐ |
| Psychiatric Problems | ☐ | Falling | ☐ |
| Paralysis | ☐ | Skin Conditions | ☐ |
| Feeding | ☐ | Special equipment/aids | ☐ |

Please expand upon any issues noted above.

## Conclusion

If there is any other information that you think would be helpful in assessing the fit of the applicant with CPPC, or if you have any information that would assist CPPC in better serving the applicant, please provide it below.

_____

_____

_____

_____

_____

_____

_____

_____

*The information in this application is accurate to the best of my knowledge.*

_____ _____

Signature Date