Society for Treatment of Autism
404 – 94th Ave SE
Calgary, AB T2J 0E8 Phone: 253-2291

RESIDENTIAL PROGRAM

Applicant's Name:______________________________ Attach one Photograph of Applicant here

Alberta Health Care No.:______________________________

Date of Birth:______________________

Gender: Male:___ Non-Binary: ____ or Female: ____ Height:______ Weight:______

Where is applicant presently residing, if different from person completing this application:

Address:____

PARENT 1/Guardian		PARENT 2/Guardian	
Name:	______________________	Name:	______________________
D.O.B.:	______________________	D.O.B.:	______________________
Address:	______________________	Address:	______________________
Occptn/Title	______________________	Occptn/Title	______________________
Company:	______________________	Company:	______________________
Phone: Home:	______________________	Phone: Home:	______________________
Work:	______________________	Work:	______________________
Cell:	______________________	Cell:	______________________
Email:	______________________	Email:	______________________

Marital Status: Single ☐ Married ☐ Divorced ☐ Common Law ☐

Are there any Guardianship or Custody orders in place: Yes ☐ No ☐ N/A ☐

What person, if parent(s) unavailable, could be contacted in an emergency?

Name:__________________________ Phone: (home)__________________

Address:________________________ Phone: (work)__________________

Relationship to Applicant:______________ Phone: (cell)__________________

Languages spoken within the family home:______________________________

LIST BROTHERS AND SISTERS OF THE APPLICANT

NAME	GENDER	D.O.B.	LIVING AT HOME
____________________________	_________	______________	__ Yes __ No
____________________________	_________	______________	__ Yes __ No
____________________________	_________	______________	__ Yes __ No

OTHER PEOPLE LIVING IN THE SAME HOUSEHOLD AS APPLICANT:

NAME	GENDER	D.O.B.	RELATIONSHIP TO APPLICANT
____________________________	__________	______________	_________________
____________________________	__________	______________	_________________
____________________________	__________	______________	_________________

DEVELOPMENTAL HISTORY

Duration of Pregnancy: Full Term? ___ Premature? ______ Birth Weight:________

Nature of Delivery: Natural? ___ Caesarian? ___ Breech? ___ Forceps? ___

Condition of applicant at birth: ____

____

Health following birth:____

If applicant was adopted: Date of legal adoption: ____________________

Age when placed in home? ________

At what age did applicant sit without support? ______ Crawl? _______ Stand? _____ Walk? _____

At what age did applicant say first understandable word or words?

____

At what age did applicant say first understandable phrases or sentences?

____

At what age did applicant begin showing attempts to dress and undress self?

____

Is applicant right or left hand dominant? _________

If there is a history of convulsive, seizure, or epileptic disorder, please answer the following questions:

At what age did the applicant experience the first seizure? ____________________

How severe? (Describe): ________________________________

Describe current seizures/disorder: ________________________________

How often? ________________________________

Under any particular circumstances?________________________________

____

Approximate date of last seizure ____________________

NB: Please list any ongoing medication on the Medical History below.

Please list any behaviours that are of concern (and estimated frequency, i.e., times per day/week):

____

____

____

____

How are each of these behaviours managed?

____

____

____

____

Please describe your long-range goals and expectations for the applicant:

____

____

____

____

____

____

____

MEDICAL HISTORY

List any childhood diseases, operations, significant illnesses, or other pertinent information (i.e., medicine applicant is currently taking) pertaining to the applicant's medical history, including all hospitalizations:

____

____

____

____

____

____

List any allergies the applicant has:

____

____

____

Applicant's **Family Physician**: NAME:______________________________

ADDRESS:______________________________ PHONE: ____________

When was the last time the applicant had a complete physical examination?: ____________

Applicant's **Dentist:** NAME:______________________________

ADDRESS:______________________________ PHONE: ____________

When was the applicant's last complete dental examination? ____________________

Applicant's **Optometrist:** NAME: ______________________________

ADDRESS:______________________________ PHONE: ____________

When was the applicant's last complete eye examination? ____________________

Does the applicant wear glasses or were they prescribed? Yes ☐ No ☐

Has the applicant’s hearing been tested:

____

When/who completed the testing (please provide report, if available)?

____

Please attach a copy of the applicant's immunization history.

Please comment on the types of food that the applicant eats.

____

____

____

____

Does the applicant have a restricted diet? ___ YES ___ NO

If yes, describe how the applicant's diet is restricted and why it is restricted:

____

____

____

PROFESSIONAL CONTACT HISTORY

Please list all doctors and other health care professionals (not previously listed) who are **currently involved** or have been **previously involved** in the diagnosis and/or treatment of this applicant, and the title/specialty of each:

NAME:___________________________TITLE:_____________CURRENT___________PREVIOUS__________

NAME:___________________________TITLE:_____________CURRENT___________PREVIOUS__________

NAME:___________________________TITLE:_____________CURRENT___________PREVIOUS__________

NAME:___________________________TITLE:_____________CURRENT___________PREVIOUS__________

NAME:___________________________TITLE:_____________CURRENT___________PREVIOUS__________

NAME:___________________________TITLE:_____________CURRENT___________PREVIOUS__________

NAME:___________________________TITLE:_____________CURRENT___________PREVIOUS__________

EDUCATIONAL HISTORY

SCHOOL	LOCATION	DATES FROM	DATES TO	COMMENTS

Current Teacher: ____

How would you describe the applicant's performance in school?

____

____

____

____

Please add here any additional remarks that would contribute to a fuller understanding of the applicant:

____

____

____

____

NAME OF PERSON COMPLETING
THIS APPLICATION: ____

SIGNATURE OF PERSON COMPLETING THIS APPLICATION:______________________________

RELATIONSHIP TO APPLICANT (IF NOT ALREADY SPECIFIED)____________________________

ADDRESS AND PHONE NUMBER, IF NOT ALREADY LISTED ON THIS APPLICATION:

____

DATE FORM COMPLETED: ____