Applewood Academy
FOR PROGRESSIVE LEARNING

CLIENT APPLICATION

Date Submitted:

CLIENT APPLICATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Student Name (last, first):			
☐ M ☐ F		DOB (mm/dd/yyyy):	
Parents/Guardians:			
Address:			Postal Code:
Telephone(s):	Home:	Cell:	Work:
OHIP#:			
Previous School:		Teacher/Grade:	

PRESENTING PROBLEMS AT TIME OF APPLICATION (please check all applicable)			
"Suicidal"Self Harm	☐ Yes ☐ No	Substance Abuse	☐ Yes ☐ No
Depressed/Withdrawn	☐ Yes ☐ No	Learning Difficulties	☐ Yes ☐ No
Physical Aggression	☐ Yes ☐ No	Unusual Behaviours	☐ Yes ☐ No
Property Destruction	☐ Yes ☐ No	Steals	☐ Yes ☐ No
Parent/Child Conflict	☐ Yes ☐ No	Authority Conflicts	☐ Yes ☐ No
Sexual Abuse Trauma	☐ Yes ☐ No	Y.O.A. (On Probation)	☐ Yes ☐ No
Eating Disorder	☐ Yes ☐ No	Other:	

PREVIOUS PSYCHOMETRIC AND / OR EDUCATIONAL ASSESSMENTS		
Date	Type/Source	Comments/Results

OUTSIDE AGENCIES INVOLVED		
Agency/Dates	Interventions Used	Comments/Results

SCHOOL HISTORY OF INTERVENTIONS (Include documentation of strategies, personnel and resources that have been employed in the past)		
Date Implemented & Duration	Program Description	Results of Interventions