Original Date:	Feb.2009
Dates Revised:	Feb.2016

APPLICATION FOR ADMISSION
HARMONY IN ACTION

Name *(Last, First, M.I.)*:		☐ M ☐ F ☐ T	**DOB:**	
Address:		**Phone Number:**		

Name of Parent (s) or Guardian (s):

Name of person completing this application:

How did you hear about us?

Does the Applicant have a court appointed legal guardian? Yes No

Level of family involvement: Intensive Frequent Occasional None

Diagnosis of Applicant Disability:

RESIDENTIAL STATUS

Where does the Applicant currently live? Family Guardian Other Supported Living Independently

Reason for interest in program?

Expected start date:

Is this your first attempt to obtain outside day programs? Yes No (If no, Please explain previous attempts and outcomes)

PREVIOUS DAY PROGRAM PLACEMENTS (attach additional sheets if needed)

Where	When	Reason for Leaving

Self-Care Ability (circle one)				OTHER COMMENTS (i.e. Note any special equipment needed)
Bathing	Assistance Needed	Reminders Needed	Independent	
Dressing	Assistance Needed	Reminders Needed	Independent	
Toileting	Assistance Needed	Reminders Needed	Independent	
Feeding	Assistance Needed	Reminders Needed	Independent	
Cognitive Skills	Good	Fair	Poor	**IQ:**
Physical Coordination	Good	Fair	Poor	
Ability to understand and follow instructions	Understands Everything	Understands Most Things	Some Difficulty Understanding Others	

Speech/Communication Skills	Good	Fair	Poor	
Ability to Develop Relationships	Good	Fair	Poor	

Social & Behavioural Information		
Leisure Activities Enjoyed:		
1.	4.	7.
2.	5.	8.
3.	6.	9.

Behavioural Concerns and Severity
Primary Means of Communication:
Describe the nature of the Applicant's abilities and disabilities

INCOME/FINANCIAL RESPONSIBILITY	
Financial Responsibility for HIA fees will be assumed by:	
Name:	Relation to Applicant
Address:	Phone Number: H. C.
Comments:	

Parent Guardian Information		
	Mother (female guardian)	Father (male guardian)
Name		
Date of Birth		
Address		
City, Province, Postal Code		
Phone		
Occupation		
Email		
Employed by		
Business Address		

City, Province, Postal Code		
Business Phone		
Date of Court Decree (if guardian)		
Marital Status of Parents:		

I understand this is a preliminary application only and completion of this form does not create any obligation or duty for Harmony In Action to provide a day program placement to the Applicant.

Signature of Person Completing Application

Date

Harmony In Action

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HEALTH HISTORY QUESTIONNAIRE
HARMONY IN ACTION

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

Name *(Last, First, M.I.):* ☐ M ☐ F ☐ T	**DOB:**
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Diagnosis of Disability: (Please be specific about your disability)

List any Diagnosed Medical Conditions

Ambulatory: Yes No Assistive Devices: (List types of devices)

Seizures: Yes No (If yes, state type of seizure)

Surgeries

Year	Reason	Hospital

Hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to Medications	
Name the Drug	Reaction You Had

Allergies to Food	
Food	Reaction You Had

Special Nutritional Concerns: **Height:** **Weight:**

Special Dietary Needs: **Diabetes:** Yes No

Immunizations Current: Yes No **Notes:**

Vision: OK Glasses Required Partially Sighted Blind **Describe:**

Hearing: OK Hearing Impaired Amplification Deaf **Describe:**

Chronic Medical Problems:

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.			
Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Has the applicant been evaluated in any of the following areas? (If yes, please note the date of the most recent evaluation and the evaluator, if known):

Type of Evaluation	Yes	No	Date of Evaluation	Evaluator or Physician
Physical Therapy				
Occupational Therapy				
Speech Therapy				
Audiological				
Visual				
Dental				
Psychological				
Other Type: (please list)				

Insurance Information		
OHIP Number:	VC	Dental Carrier:
Prescription Carrier:		Hospital Preference: