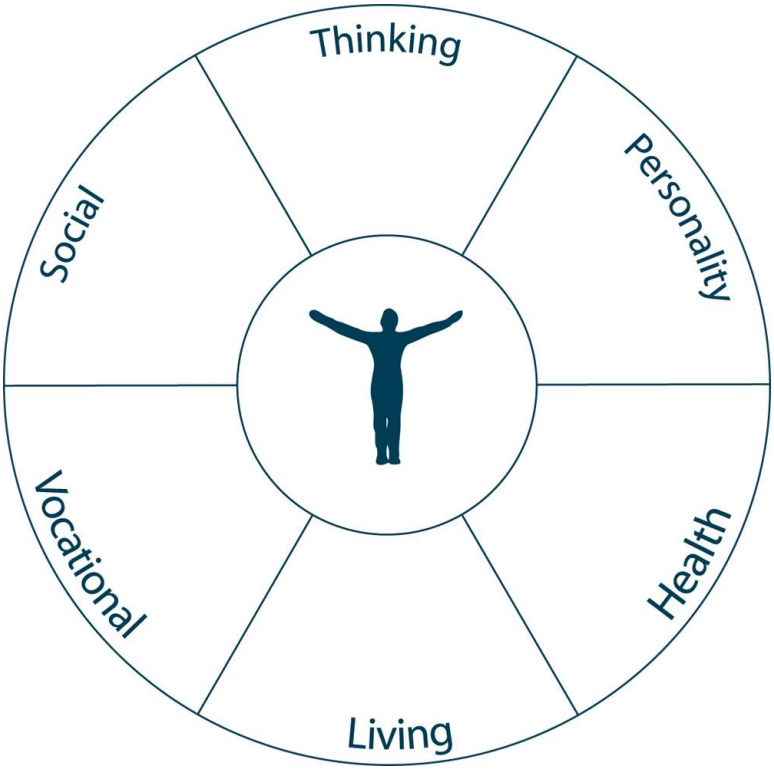
The Brain Injury Rehabilitation Center

Brain Injury Rehabilitation Services for the Whole Person

www.brainrehab.org



The Brain Injury Rehabilitation Center
Application for Brain Injury Rehabilitation

Return information to: □ **Director** **(605) 343-7297**
The Brain Injury Rehabilitation Center
803 Soo San Drive
Rapid City, SD 57702

GENERAL INFORMATION		
Legal Name (First)	**(Middle)**	**(Last)**
Current Address:		**Phone #**
City	**State**	**Zip**
Social Security Number:		**Date of Birth**
Sex	**Height**	**Weight**
Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed_____		

LEGAL INFORMATION		
Is applicant a minor or been declared incompetent by a judge? Yes_____ No _____		
Legal Guardian: *(Please attach copies of guardianship papers if applicable)* **Name:**		
Current Address:		**Phone #**
City	**State**	**ZIP**
Does Applicant have any prior legal convictions? Yes _____ No _____ **If yes, felony or misdemeanor?** **Most serious charges:**		

MEDICAL		
List known allergies:		
Any medical problems prior to injury? Describe:		
Cause of brain injury:	**Date of brain injury:**	**Age at injury:**
Dates of other head injuries and cause of injury:		
Does the applicant have seizures? Yes _____ No _____ Type of Seizures:		

Other Medical Concerns:
Does applicant currently operate a motor vehicle? Yes _____ No _____
Did applicant consume alcohol and/or non-prescription drugs prior to injury? **Yes _____ No _____ If so, what type and how often?**

CURRENT PRESCRIPTION MEDICATIONS		
Name of Medication	**Dosage and Frequency**	**Prescribing Doctor**
Current Primary Physician:		**Date of last exam**
Address		**Phone #**
City	**ST**	**ZIP**

FAMILY		
Name of Spouse		**Married how long?**
Children of Applicant:		
NAME	**AGE**	**GENDER**

EDUCATION	
Highest Grade Completed: _____ H.S. Diploma or GED: _____ **Was applicant in any special classes? Yes _____ No _____**	
Other Degrees or Diplomas Earned:	
Best Subjects:	**Worst Subjects:**
Colleges/Trade Schools Attended:	

VOCATIONAL

Name of Most Recent or Current Employer:	**Dates of Employment:**
Address:	
Job Responsibilities:	
Reason for Leaving (if applicable):	**Wage:**

Most significant former Employment:	**Dates of Employment:**
Address:	
Job Responsibilities:	
Reason for Leaving:	**Wage:**

MILITARY SERVICES

Have you served in any of the US military branches? Yes _____ No _____
Branch_____

Are you eligible for VA benefits? Yes _____ No _____

FINANCIAL INFORMATION

Have you applied for Social Security Benefits? Yes _____ No _____ Result: _____

Social Security Amount: _____ SSI Amount: _____

Other Source of Income: _____ Amount: _____

INSURANCE INFORMATION

Medicaid #: _____ Medicare #: _____

Private Health Insurance: Yes _____ No _____ (If "Yes," please list below):

_____

(Company) (Address) (Policy Number)

PERSONALITY		
Circle all the words below that describe the applicant BEFORE THE INJURY	**Circle all the words below that describe the applicant SINCE THE INJURY**	**Comments:**
Happy	Happy	
Depressed	Depressed	
Impulsive	Impulsive	
Self-controlled	Self-controlled	
Meticulous	Meticulous	
Neglectful	Neglectful	
Strong-Willed	Strong-Willed	
Apathetic	Apathetic	
Out-going	Out-going	
Shy	Shy	
Cooperative	Cooperative	
Uncooperative	Uncooperative	
Anxious	Anxious	
Calm	Calm	
Sexually Aggressive	Sexually Aggressive	
Physically Aggressive	Physically Aggressive	
Patient	Patient	
Impatient	Impatient	
Other:	Other:	
What is most frustrating for the applicant to deal with since the injury?		
Applicant's desired outcome of treatment?		
Applicant's life goals?		

IN CASE OF EMERGENCY		
Name		**Home Phone**
Address		**Work Phone**
City	**ST**	**ZIP**
Name		**Home Phone**
Address		**Work Phone**
City	**ST**	**ZIP**

NOTE: Please attach any medical information that you may have regarding your brain injury, particularly any neuropsychological evaluations, discharge summaries, or any other evaluations.

The Brain Injury Rehabilitation Center
INITIAL PHYSICAL EXAMINATION

This form must be completed and signed by a licensed physician.

Applicant Name:_____ Sex _____ DOB _____

HAS THE PATIENT SUFFERED FROM ANY OF THE FOLLOWING: (PLACE X)		
_____Frequent headaches	_____Hemorrhoids	_____Burning on urination
_____Difficulty with vision	_____Fainting	_____Blood in urine
_____Difficulty with hearing	_____Chest pain	_____Excessive fatigue
_____Asthma/hay fever	_____Unusual weight loss/gain	_____Shortness of breath
_____Persistent cough	_____Cough producing blood	_____Unusual irritability
_____Swollen ankles	_____Loss of appetite	_____Frequent indigestion
_____Varicose veins	_____Diarrhea/constipation	_____Ulcers
_____Hernia (Rupture)	_____Accidents (Describe)	_____Fractures (Describe)
_____Other (Describe)	_____Operations (Describe)	_____Seizures
Describe:		
If seizures, are seizures controlled? Yes No Frequency_____ Type_____		

PHYSICAL EXAMINATION: PLEASE CHECK ITEMS THAT WERE EXAMINED AND FOUND TO BE NORMAL. DESCRIBE ABNORMAL FINDINGS.		
Height (w/o shoes)	Weight	Temperature F
Blood Pressure	Pulse	Respirations
Eyes: R L	Nose:	Throat:
Ears: R L	Mouth:	Neck:
Lungs: R L	Heart:	Abdomen:
Pelvic: Prostrate:	Feet:	Lab: CBC _____ CCB _____ PAP _____ Thyroid _____ UA _____ Blood Sugar _____
Pre-Admission TB results:	Date:	
Pre-Admission HEP B screening results:	Date:	
Orthopedic Impairment: (Describe)		

Physical Activities: Normal _____ Limited _____ (Explain)
Exercise Program: Walking or Treadmill _____ Times per week_____ Minutes _____

Work and/or activities to be avoided:

Current Diet:	Changes:

Allergies:

CURRENT PRESCRIPTION MEDICATIONS

Name of Medication	Dosage and Frequency	Prescribing Doctor

May patient self-administer medications with supervision? Yes No

WHICH OF THESE OVER THE COUNTER MEDICATIONS MAY THE CLIENT TAKE PRN PER PACKAGE INSTRUCTIONS?

Yes	No	Acetaminophen	Yes	No	Cepastat lozenges	Yes	No	Sun Screen
Yes	No	Ibuprofen	Yes	No	Bacitracin Oint	Yes	No	Midol
Yes	No	Pepto-Bismol	Yes	No	Hydrocortisone Cr	Yes	No	M.O.M.
Yes	No	Maalox	Yes	No	Debrox Eardrops	Yes	No	Sudafed
Yes	No	Tums	Yes	No	Calamine lotion	Yes	No	Benadryl
Yes	No	Kaopectate	Yes	No	Tinactin cr/pwdr	Yes	No	Cough Drops
			Yes	No	Robitussin Syrup			

Does this individual have a Brain Injury? Yes No
Comment:

Is this individual medically stable? Yes No
Comment:

Does this individual need daily nursing services? Yes No
Comment:

Is the disability likely to continue indefinitely? Yes No
Comment:

Physician Signature	Date
Print Name	Phone #
Address: City	ST ZIP