

Midwest Brain Injury Clubhouse
Member Application

Today's Date:	Referral Date:	Completed by:
Last Name:		First:
Home Address:		
City:	State:	Zip: County:
Home Telephone:		Cell or work:
Date of Birth:	Gender:	Age: Age at Injury:
Primary Language:		
Marital status: Single / Married / Divorced / Widowed / Separated		
Demographic Information:		
<input type="checkbox"/> American Indian	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> White
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> African-American	<input type="checkbox"/> Filipino
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Mixed ethnicity	
<input type="checkbox"/> Asian	<input type="checkbox"/> Alaskan Native	
Email Address:		
Legal guardian or Power of Attorney:		
Employer:	Occupation:	
Work Address:		
Employer's Phone:		
Para Transit Number: P		

REFERRAL SOURCE

Name: _____
 Agency/Organization: _____
 Policy Number: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Office: (_____) _____ Fax: (_____) _____

FUNDING SOURCE: private pay/ TBI waver /Workers Comp (# of approved days)

WORKERS COMP/CLAIMS ADJUSTER (if applicable)

Name: _____

Agency/Organization: _____

Policy Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Office: (_____) _____ Fax: (_____) _____

CASE MANAGEMENT AGENCY/ CASE MANAGER (if applicable)

Name: _____

Agency/Organization: _____

Policy Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Office: (_____) _____ Fax : (_____) _____

INSURANCE PROVIDER (if applicable)

Agency/Organization: _____

Policy Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Office: (_____) _____ Fax: (_____) _____

MEDICARE/MEDICAID (if applicable)

Medicare / Medicaid No.: _____

Estimated Income per Month: \$ _____ Per year: \$ _____

Monthly Household Income (for discounted rates): \$ _____

MEDICAL/ INJURY HISTORY

PHYSICIAN/MEDICAL PROVIDER (attach additional information if necessary)

Do you have a physician?

Yes

No

If Yes, please provide the names of providers in the spaces below. (attach additional information if necessary)

Physician 1

Name: _____
Agency/Organization: _____
Address: _____
City: _____ State: _____ Zip: _____
Office: (_____) _____ Fax :(_____) _____

Physician 2

Name: _____
Agency/Organization: _____
Address: _____
City: _____ State: _____ Zip: _____
Office: (_____) _____ Fax :(_____) _____

Physician 3

Name: _____
Agency/Organization: _____
Address: _____
City: _____ State: _____ Zip: _____
Office: (_____) _____ Fax :(_____) _____

Have you had a physical exam in the last 12 months?

Yes No
Write month/year of most recent exam _____

Do you have a dentist?

Yes No
Write month/year of most recent exam _____

Have you had a dental exam or cleaning in the last 12 months?

Yes No
Write month/year of most recent exam _____

Have you been hospitalized recently?

Yes No

Do you anticipate any upcoming hospitalizations or medical procedures?

Yes No

For female members only:

Have you had a gynecological exam in the last 12 months?

Yes No

Are you currently pregnant?

- If yes, how far along is the pregnancy?
- No

Do you receive services from the following providers:

- Neurologist
- Audiologist
- Dietician
- Occupational or Physical Therapist
- Speech /Language Pathologist
- Other Specialist_____

Do you use any type of assistive device?

- Yes
- No

List devices:_____

Overall, how would you describe your current health?

- Excellent
- Good
- Fair
- Poor

Height: ____' ____” Weight: _____ lbs.

What type of brain injury did you have?

- Traumatic
- Brain tumor
- Hypoxia - Lack of oxygen due to cardiac arrest, drowning, carbon monoxide poisoning, respiratory issues
- Aneurysm
- Epilepsy
- Stroke
- Infection, meningitis, encephalitis
- Drug or alcohol overdose or abuse
- Other:_____

If a traumatic injury, how did your accident happen?

- Car accident
- Motorcycle accident
- Pedestrian hit
- Bicycle accident
- Fall
- Violence (beating)
- Gunshot wound
- Military Action

Other _____

Did your injury occur at work?

- Yes
- No

How much supervision is needed?

- 24 hour supervision at home and community
- Supervision periodically
- Supervision in the community only

Do you have any food allergies or medications?

- No
- If yes, explain

In addition to your brain injury, have you currently or in the past had any of the following medical problems or symptoms?

- | | |
|---|---|
| <input type="radio"/> Alzheimer’s Disease/Dementia | <input type="radio"/> High cholesterol |
| <input type="radio"/> Arthritis | <input type="radio"/> Hyperglycemia/ Hypoglycemia |
| <input type="radio"/> Autoimmune disorder (Lupus, Rheumatoid arthritis) | <input type="radio"/> Incontinence |
| <input type="radio"/> Asthma | <input type="radio"/> Infections/Colds/Flu (frequent) |
| <input type="radio"/> Birth Defects | <input type="radio"/> Low Energy (frequent) |
| <input type="radio"/> Breathing Problems | <input type="radio"/> Low Blood Pressure |
| <input type="radio"/> Cancer/ Tumor | <input type="radio"/> Mental health (depression, bi-polar, anxiety) |
| <input type="radio"/> Chronic Pain | <input type="radio"/> Overweight/Obesity |
| <input type="radio"/> Diabetes | <input type="radio"/> Seizures/Convulsions |
| <input type="radio"/> Dizziness | <input type="radio"/> Substance abuse (drug or alcohol) |
| <input type="radio"/> Epilepsy or seizure disorder | <input type="radio"/> Swallowing problems |
| <input type="radio"/> Fatigue (frequent) | <input type="radio"/> Thirst (excessive) |
| <input type="radio"/> Glaucoma | <input type="radio"/> Under eating |
| <input type="radio"/> Headaches (frequent) | <input type="radio"/> Visual Problems |
| <input type="radio"/> Hearing Problems | <input type="radio"/> Other: |
| <input type="radio"/> Heart Disease/Problems | _____ |
| <input type="radio"/> Hepatitis | _____ |
| <input type="radio"/> High Blood Pressure | _____ |

INJURY SPECIFICS

Which areas of physical conditions do you have limitation?

- | | | |
|---|--|---|
| <input type="radio"/> Difficulty walking | <input type="radio"/> Poor endurance | <input type="radio"/> Tremors or spasticity |
| <input type="radio"/> Balance | <input type="radio"/> Trouble with daily living skills | <input type="radio"/> No issues |
| <input type="radio"/> Paralysis or weakness | | |

Which areas of thinking do you have limitations?

- | | |
|---|--|
| <input type="radio"/> Attention or concentration | <input type="radio"/> Judgment and awareness |
| <input type="radio"/> Word finding deficits | <input type="radio"/> Slowed processing |
| <input type="radio"/> Memory | <input type="radio"/> Initiation |
| <input type="radio"/> Problem solving or decision making difficulties | |

Which areas of language and speech do you have limitations?

- Difficulty speaking
- Difficulty following directions or conversation
- Difficulty writing
- Difficulty reading
- Word finding problems

Which areas of vision do you have limitations?

- Difficulty seeing clearly – need large print
- Double vision
- Problems with bright light
- Wears glasses

Do you have any limitations regarding hearing?

- Yes
- No

What are your limitations regarding emotional issues?

- Easily frustrated
- Cry easier
- Frequently yell
- Throw or hit things
- Trouble coping
- Personality changes
- Feel depressed or sad

BEHAVIORAL HISTORY

Is there a history of any of the following:

- Aggressive Behavior
- Alcohol Overuse/Abuse
- Anger Outbursts
- Attention Seeking Behaviors
- Avoidance of Situations
- Chronic Lying
- Chronic Pain
- Clinginess
- Cognitive Impairment (thinking)
- Communication Problems
- Compulsive Behaviors
- Delusions
- Depressed Mood
- Detachment from Others
- Distractibility
- Distrustful
- Diminished Interest in Activities
- Drug Abuse
- Easily Loses Temper
- Encopresis (soiling self)
- Enuresis (wetting self)
- Excessive Dependency on Others
- Excessive Goal-Directed Behaviors
- Fatigue/ Low Energy
- Gender confusion/ Concerns
- Hallucinations
- Hyperactivity
- Inattention
- Insomnia
- Intrusive Memories
- Impulsivity
- Immaturity
- Inappropriate Sexual Behaviors
- Indiscriminate Sociability
- Irritability
- Low Self Esteem
- Lack of Attachment
- Learning Problems
- Memory Impairment
- Mood Swings
- Motor Skill Problems
- Not Trustworthy
- Oppositional Behavior
- Paranoia

- Poor Concentration
- Poor Hygiene/Grooming
- Poor Peer Relationships
- Property Destruction
- Repeats words of others
- Repetitive Behaviors
- Restlessness
- Self Injurious Threats
- Sexual Dysfunction
- Sexual Arousal Concerns/Addictions
- Sexual Promiscuity
- Social Discomfort/ Isolation
- Stealing
- Tics/Twitches
- Unstable Interpersonal Relationships

PSYCHIATRIC HISTORY

Mental Health Professional (if applicable)

Name: _____

Agency/Organization: _____

Policy Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Office: (_____) _____ Fax: (_____) _____

Have you ever been diagnosed with any of the following:

- No Past Diagnosis
- Unknown/Unsure
- ADHD/ADD
- Adjustment Disorder
- Asperger's
- Autism
- Bipolar Disorder
- Dementia/Delirium
- Depression
- Dissociative Disorder
- Eating Disorder
- Generalized Anxiety Disorder
- Obsessive Compulsive Disorder
- Oppositional Defiant Disorder
- Panic Disorder
- Personality Disorder
- PTSD
- Reactive Attachment Disorder
- Schizophrenia
- Sexual Disorder
- Sleep Disorder
- Other _____

Have you ever experienced suicidal or homicidal thoughts?

- Yes
- No

Is there a family history of Mental Health problems?

- Yes
- No

SUBSTANCE ABUSE HISTORY:

Is there a family history of substance abuse/dependence?

- Yes No

Fill in the table as applicable to you:

Substance	Average Amount	Frequency	Current Use
Alcohol		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amphetamines/Speed		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
Barbiturates/Downers		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cocaine		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crack Cocaine		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hallucinogens (i.e., LSD)		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inhalants (i.e., Glue, Gas)		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
Marijuana		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
Methamphetamines		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nicotine/Cigarettes		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
PCP		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prescription		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever received treatment for substance abuse/dependence?

- Yes No

Are you interested in receiving information on treatment for substance abuse/dependence?

- Yes No

SEXUAL ABUSE HISTORY:

Have you ever been raped, molested, or sexually abused?

- Yes No

Have you ever been the perpetrator of sexual abuse?

- Yes No

SOCIAL INFORMATION:

Since your injury, has your life changed regarding your family?

- Yes No

Would you say your life has changed regarding friends?

- Yes No

Are you satisfied with your situation regarding friends?

- Yes No

Has your situation changed regarding romantic relationships?

- Yes No

Are you satisfied with your romantic situation?

- Yes No

Do you have children?

- If yes, how many _____ No

Do you have legal custody of your child/children?

- Yes If No, who does? _____

How is your current family experience?

- Outstanding Witness to abuse
 Normal Victim of abuse
 Chaotic

Do you participate in any recreational activities?

- Yes No

If no, were you involved in any recreational activities prior to your injury?

- Yes No

Do you participate in any religious/spiritual activities?

- Yes No

Are you satisfied with your leisure time activities?

- Yes No

What is the #1 reason you are seeking services here at the Clubhouse?

- Improve skills
- Socialize
- Return to work
- Be more active
- Respite for family or caregiver

EDUCATION

What of the following degree have you completed?

- Grade school
- High school or GED
- Technical Training
- Some College
- Associate Degree (2 yrs)
- Bachelors Degree
- Masters degree
- Doctorate or professional degree

Did you have an Individualized Education Plan (IEP)? Yes

- Yes
- No

WORK HISTORY

Are you currently employed?

- Yes
- No

If yes, where do you work? _____

How many hours per week? _____

Are you currently performing the same job you had prior to your brain injury?

- Yes
- No

If no, what job did you perform prior to your injury? _____

Do you volunteer?

- Yes
- No

If yes, where do you volunteer? _____

How many hours per week? _____

MILITARY HISTORY

Have you ever served in the Military?

- Yes
- No

If yes, please pick one of the following:

- Active Reservist
- Dishonorably Discharged
- Honorably Discharged

LIVING ARRANGEMENTS

Where do you live?

- House, condo or town home
- Nursing home
- Apartment
- Supportive living residences

Is your home handicap accessible/ suitable for post injury needs?

- Yes
- No

Who do you live with?

- Self
- Spouse
- Parents or siblings
- Boyfriend / girlfriend
- Roommate
- Other_____
- Caregiver
- Children

How many people are in your household? _____

Has your living situation changed since your injury?

- Yes
- No

Are you satisfied with your living situation?

- Yes
- No

TRANSPORTATION

What is your primary mode of transportation?

- Drive self - Car
- Walk
- Public transportation (bus, train, taxi)
- Rides from friends/family
- Para Transit services (PACE)
- Bicycle

Are you able to drive?

- Yes No

Has your mode of transportation changed since your injury?

- Yes No

LEGAL HISTORY:

Are you currently on Parole/ Probation?

- Yes No

Have you ever been convicted of a misdemeanor?

- Yes No

If yes, # of times ____

Non substance related crimes (describe the charges) _____

Substance related crimes (describe the charges) _____

Have you ever been convicted of a felony:

- Yes No

If yes, # of times ____

Non substance related crimes (describe the charges) _____

Substance related crimes (describe the charges) _____

Have you ever been incarcerated? (If yes complete the following)

- Yes No

	Number of Times	Total Time Served (days, weeks, months, years)
Jail		
Prison		
Pre release		
Other		

MEMBER NEEDS ASSESSMENT

How would you rate your overall satisfaction with your life?

- | | | | | |
|------------------------|-----------------------|-------------|---------------------|----------------|
| 1 | 2 | 3 | 4 | 5 |
| Completely Unsatisfied | Somewhat dissatisfied | Indifferent | Basically Satisfied | Very Satisfied |

FAMILY NEEDS QUESTIONARE – for families or caregivers to complete only

We realize that families of those with brain injury provide valuable support to these loved ones for a lifetime. Resources and support are necessary for the well being of **ALL** involved

The Clubhouse frequently has guests speak on a variety of topics. Are there any topics that you would like more information on?

What is the best way to communicate with you?

What are resources that you would like more information on?

- | | |
|---|--|
| <input type="checkbox"/> Caregivers | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Healthcare professionals | <input type="checkbox"/> Accessibility & Equipment |
| <input type="checkbox"/> Support Groups | <input type="checkbox"/> Respite Care |
| <input type="checkbox"/> Housekeeping | <input type="checkbox"/> Disability Groups |
| <input type="checkbox"/> Stress Management | <input type="checkbox"/> Legal Advice |
| <input type="checkbox"/> Financial Resources | |
| <input type="checkbox"/> Other: _____ | |

SIGNATURE PAGE

I verify that all information contained in the application is correct and valid.

I understand that at any time my membership may be revoked if any information found in this application is deemed to be invalid or untruthful.

Signature

Date