BROWNWOOD LIFE CARE CENTER

7500 WELLS LAKE ROAD
FORT SMITH, AR 72916
PHONE: (479) 785-2273 FAX: (479) 785-0583

IDENTIFYING INFORMATION

Child's Name: _____SSN_____ Birthdate:_____
Sex: M F HEIGHT: _____ WEIGHT: _____ Birthplace: _____
Parent / Guardian Name: _____
Parent / Guardian Street Address: _____

_____
City State Zip Code County
Guardian Phone Numbers: _____
HOME WORK CELL
Contact Person: _____ Phone Number _____
Diagnosis: _____

_____

_____
Allergies: _____
Is applicant currently in a hospital or residential facility? Y/N DISCHARGE DATE: _____
Address of Facility: _____

FINANCIAL INFORMATION

Financial Sources : MEDICAID SSI PRIVATE INSURANCE MEDICARE CHILD SUPPORT
Private Insurance: _____
Provider Name Group # ID# Subscriber Name
Billing Address:_____Phone:_____
Medicaid Number: _____ Medicare Number: _____
Monthly SSI/SSA Income: _____ Child Support Payment: _____

FAMILY DATA

Father
Name: _____Birthdate: _____SSN_____
Address: _____
Street City State Zip
_(____)_____(____)_____(____)_____
HOME Number WORK Number CELL Number
Employer: _____ Occupation: _____

Mother

Name: _____Birthdate: _____SSN_____

Address: _____

Street City State Zip

_(____)_____(____)_____(____)_____

HOME Number WORK Number CELL Number

Employer: _____ Occupation: _____

Marital Status of Parents:

Married Separated Divorced Widowed Never Married

Siblings

List Names of all brothers / sisters:

Name Birthdate Living at home?

_____

_____

_____

_____

_____

List other people living in the home:

Name Birthdate Relationship

_____

_____

_____

_____

_____

MEDICAL INFORMATION

Name of Primary Physician: _____Phone Number:_____

Office Address: _____

Street City State Zip

Date of last eye exam: _____ Physician: _____Phone: _____

Results: _____

Date of last hearing exam: _____Physician:_____Phone:_____

Results: _____

Date of last swallow study:_____Physician:_____Phone:_____

Results: _____

Are vaccinations current? _____Received where? _____

At what age was child's handicap first noticed? _____

Dentist: _____

Name Address Telephone #

Any dental issues? _____

Date of last visit: _____

List all Surgeries

Type	Date	Physician	Hospital

List Current Medications

Name	Dosage	Purpose

Family Medical History

Is there a history of any of the following in the child's family?

	YES	NO	RELATIONSHIP
Hypertension			
Heart Disease			
Thyroid Disease			
Kidney Disease			
Liver Disease			
Learning Disability			
Mental Retardation			
Seizure Disorder			
Vision Disability			
Birth Defects			
Muscle Problems			
Tuberculosis			
Diabetes			
Hearing Disorder			
Lung Disease			
Cancer / Tumors			
Nervous Disorders			
Venereal Disease			
Injury during pregnancy			

List any allergies to medications:

_____

_____

Prenatal Information

Did mother receive prenatal care? _____
Physician: _____ Phone Number: _____
Were there any complications with Pregnancy? Please describe:

_____

_____

_____

Where was child born? _____
Was child premature? _____ How early? _____
Birth weight: _____Birth length: _____

BEHAVIORS

Does the child: Hit self Hit others Bite Self Bite others Bang Head

Any other self abusive behaviors? Please list:

_____

_____

How are these behaviors addressed?

_____

_____

Does this treatment work? _____
When does the behavior occur?

_____

_____

What happens just before the behavior?

_____

_____

What happens just after the behavior?

_____

_____

What does the child do when he/she is
Happy:

_____

_____

Sad:

_____

_____

Angry:

_____

_____

Frustrated:

_____

_____

Tired:

_____

_____

How does the child Communicate:

_____

_____

Move across a room:

_____

_____

Eat:

_____

_____

What kind of bed does the child sleep in? _____

Does the child wake often?_____Get out of bed?_____

Child's favorite activity: _____

_____

What are your child's strengths? _____

_____

What are your child's weaknesses? _____

_____

THERAPY SERVICES

Physical Therapy

Does your child currently receive physical therapy? _____

If yes, where and how often? _____

If not, has he/she received therapy in the past? _____

If yes, where? _____

Does the child….

	Yes	No	With Assistance
Roll			
Crawl			
Stand			
Walk			
Propel wheelchair			
Scoot on floor			
Pull up			
Sit independently			

Does the child have any of the following adaptive equipment?

	Yes	No	On Order through Whom?
Wheelchair			
Walker			
AFOs (Foot/Ankle Brace)			
Stander			
Car Seat			
Glasses			
Hearing Aid			
Hand splints			
TLSO (back brace)			

Occupational Therapy

Does your child currently receive Occupational Therapy? _____
If yes, when and how often? _____
If not, has he/she received therapy in the past? _____
If yes, where? _____

Please explain your child's skills in

Bathing: Independent Totally Dependent Needs Assistance (explain):

_____

_____

Toileting: Independent Totally Dependent Needs Assistance (explain):

_____

_____

Dressing: Independent Totally Dependent Needs Assistance (explain):

_____

_____

Toothbrushing: Independent Totally Dependent Needs Assistance (explain):

_____

_____

Hair-care: Independent Totally Dependent Needs Assistance (explain):

_____

_____

Feeding: Independent Totally Dependent Needs Assistance (explain):

_____

_____

NUTRITION

Food Texture (circle): Mashed Finely chopped Formula
Strained baby food Coarsely Chopped Pureed/blended
Regular Other : _____
_____

Type of Liquids (circle): Regular Thickened, what consistency?_____
_____

Are foods prepared in a special way? _____
_____

Are there any food allergies? _____
What foods does he/she like?_____
What foods does he/she dislike? _____
How would you rate his/her appetite? Good Fair Poor
Describe utensils, plate, bowl, cup used to feed child: _____
_____
Is child fed by bottle? _____**Nipple type:** _____
What formula does child use? _____

Feeding Technique

Check all that apply:

_____Tube fed only _____Must be fed by caregiver _____Feeds self with spoon
_____Drinks from cup _____Drinks from bottle _____Feeds self with fingers
_____Feeds self with fork _____Tube feedings and oral feedings

Does child have problems with……

	Yes	No
Sucking		
Swallowing		
Chewing		
Gagging		
Biting		
Lip Closure		
Drinking		

Speech Therapy

Does child currently receive speech therapy? _____
If yes, where and how often? _____
If not, has he/she received speech therapy in the past? _____
If yes where? _____

Does the child…..

	Yes	No
Make sounds		
Use words		
Use gestures		
Use sentences		
Reach for toys		
Look at books		
Pretend play		

Does the child have….

	Yes	No	On order with whom?
Communication board			
Switch			
Adaptive toys			
Electronic Comm. Device			

Education

What school is the child currently attending?_____Phone:_____
What is his/her teacher's name?_____ Grade? _____
Previous school attended? _____ Grade _____ Year _____
School District? _____County: _____
Has the child been tested by a psychologist? _____
Psychologist's name: _____Phone number: _____
Does this child have a diagnosis of mental retardation? _____
PLEASE INCLUDE COPY OF PSYCHOLOGICAL EVALUATION WITH THIS APPLICATION

PLEASE PROVIDE ANY OTHER IMPORTANT INFORMATION REGARDING APPLICANT'S STRENGTHS AND NEEDS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

BROWNWOOD LIFE CARE CENTER
CONSENT FOR RELEASE OF RECORDS

APPLICANT'S NAME: _____
DATE OF BIRTH:_____SSN: _____

I, as parent or legal guardian of _____, give my
APPLICANT'S NAME
consent for_____ to release
NAME OF FACILITY TO RELEASE RECORDS
all records pertaining to the care of my child so he/she can be considered for admission to

Brownwood Life Care Center.

Please send records to:
Brownwood Life Care Center
Attn: Savanah Organ
7500 Wells Lake Road
Fort Smith, AR 72916
Phone: (479) 785-2273
Fax: (479) 785-0583

_____ _____
SIGNATURE OF PARENT/GUARDIAN **DATE**

_____ _____
SIGNATURE OF WITNESS **DATE**