INTAKE FORM

Autism Center for Marriage and Life Skills **Jerusalem, Israel**: For Year _____

Fill in where applicable

Attach two original, current passport-size photos

_____ _____
Family Name First Middle Hebrew (First and Family)

_____
Address City State/Province Zip/Postal Code Country

_____
Mailing Address if different from above:

_____ _____
Phone –Personal E-mail address – Personal

Fax _____ Social Security Number _____

Passport Number _____ Country-Issuing Passport _____ Exp. Date_____

Date of Birth month/day/year _____ Synagogue _____

Citizenship _____ Rabbi _____
Name Phone Number

FATHER

_____
Last Name First

_____
Occupation Citizenship

_____
Business Phone Business Fax Cell Phone

_____
Address if different from the applicant

Educational Background (religious and secular) _____

_____

MOTHER

_____
Last Name First Maiden

_____
Occupation Citizenship

_____
Business Phone Business Fax Cell Phone

_____
Address if different from the applicant

Educational Background (religious and secular) _____

_____

If you live with a guardian, please write his/her name and relationship to you _____

SIBLINGS

Name	Age	School/Occupation

EDUCATION

Name of School Location Attended (from –to)

Elementary Schools _____

Secondary Schools _____

Colleges/Universities _____

Jewish Schools (if not included above) _____

Other Institutions _____

Name of Applicant _____

Write an essay on:

1. What you want to accomplish?

2. How would you describe yourself to a potential partner? <u>Be specific.</u>

3. What I am looking for in a potential partner? <u>Be specific.</u>

4. Which tools and Skills do you have to building a relationship with a spouse? <u>Be specific</u>

5. Why is marriage important to you? <u>Be specific</u>

Have you had previous relationships? Explain _____

_____

_____

_____

_____

_____

_____

Previous visits to Israel: Indicate date(s) and program(s)

_____

_____

_____

_____

_____

Work Experience

_____

_____

_____

_____

_____

Please remember to include the <u>application fee of $150</u>, <u>essay</u> and <u>two photographs</u>. The Intake Form fee is non-refundable.

Please continue on next page

MEDICAL FORM

(This information will be kept strictly confidential)

Name of Applicant _____

Father's Name _____Mother's Name _____

Parents are: Married Divorced Separated Widowed

Address _____

Phone Number _____ Date of Birth _____

Passport Number _____ Place of Birth _____

PERSON IN ISRAEL TO NOTIFY IN CASE OF EMERGENCY:

Name _____ Relationship to Applicant _____

Address _____ Phone _____

1. Are you allergic to any foods? _____

_____

2. Height _____ Weight _____
3. Have you, or any member of your family, suffered from: tuberculosis, epilepsy, emotional disturbances, heart diseases, asthma, diabetes, digestive tract diseases, other diseases? Please check the appropriate answer below. If yes, give details. Use separate sheet, if necessary.
   ( ) NO ( ) YES Details _____

   _____

   _____
4. List any hospitalization and diagnosis ( ) NONE ( ) YES Details and dates _____

   _____
5. Have you ever received psychological counseling? ( ) NO ( ) YES (Attach Reports and details)

   _____
6. Are you allergic to any medications? ( ) NO ( ) YES
   If yes, indicate which medications _____
7. List any other allergies _____
8. Have you ever suffered from an eating disorder? ( ) NO ( ) YES Details _____

   _____

Please continue on next page

MEDICAL FORM

(This information will be kept strictly confidential)

Additional Medical Information

Conditions noted on this form should be of a long term nature. Please reply as fully as possible to help us protect your son.

Loss of consciousness (LC)_____

Ear Disorder (ED) _____

Eyesight impairment (EI) _____

Respiratory disorder (RD) _____

Migraine (M) _____

Limp (L) _____

Stuttering (S) _____

Eye Squinting (ES) _____

Tics (T) _____

Uncontrollable shaking of body parts (US) _____

Uneven gait (UG) _____

Other Medical Condition (OMC) _____

_____

_____ _____

Signature or Signature Parent/Legal Guardian Date

Please continue on next page

MEDICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN

Name of Applicant_____

1. Vision _____ Hearing _____

2. General Examination	Normal	Deviation from Normal
Height	_____	_____
Weight	_____	_____
Heart	_____	_____
Lungs, Chest	_____	_____
Blood Pressure	_____	_____
Hemoglobin	_____	_____
Abdomen, Digestive Tract	_____	_____
Mouth, Throat	_____	_____
Skin	_____	_____
Spine	_____	_____
Feet	_____	_____
Nervous System	_____	_____
Allergies	_____	_____

Other remarks _____

_____

3. a) Is applicant presently receiving any medications? If so, please attach statement of such medications with dosage and directions and indication if prescription refill by the Applicant is required.

   b) List any medication that the Applicant has taken regularly at any point over the last three years. ____

   _____

   _____

4. Does the Applicant have any history of an eating or dietary disorder, or currently manifest any signs of either? ( ) NO ( ) YES

   Details _____

5. Does the applicant have any physical limitations? ( ) NO ( ) YES

   Details _____

   _____

6. Date of last tetanus immunization _____

7. Date of BCG vaccination _____

8. Are you aware of any medical issues that the applicant has? If yes, please explain

_____

9. When you think of the applicant, what are the first three adjectives that come to mind?

_____ _____ _____

I have examined the above named applicant and DO consider him physically and emotionally able to participate in your program in Israel.

Name of Physician (please print) _____

Address_____
Phone _____
Signature _____ Date _____

Please continue on next page

Name of applicant _____

Please Check the Most Appropriate Answer						
Attribute	**Always**	**Often**	**Sometimes**	**Rarely**	**Never**	**No Data**
Takes initiative						
Leader of peers						
Shows flexibility						
Willing to help others						
Considerate of others						
Relates properly to teachers						
Exhibits a warm, caring personality						
Copes well with setbacks						
Accepts personal responsibility						
Is honest and straightforward						

(*Please continue on next page*)

Name of Applicant _____

Please Check the Most Appropriate Answer					
	Below Average	**Average**	**Good**	**Very Good**	**No Data**
Critical and questioning attitude					
Pursuit of independent living					
Disciplined work habits					
Self confidence					
Interest in religious growth					

Consent Form

I CONSENT to the collection, disclosure, and use of my personal and health information for educational and therapeutic purposes to help in my treatment and education.

_____

Client– signature

_____

Please print name

_____

Date