Boston University College of Health & Rehabilitation Sciences: Sargent College
Center for Psychiatric Rehabilitation

Stephanie Cummings, Administrative Manager
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940 Commonwealth Avenue West
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RECOVERY SERVICES

STUDENT APPLICATION PACKET

Instructions: Please complete all 8 parts of your Student Application Packet, and fax it to Stephanie Cummings at (617) 353-7700. After receiving your packet, she will contact before the start of the upcoming semester to arrange a short and sweet interview. If you have any questions about the application process or services offered at the Center for Psychiatric Rehabilitation, please refer to the "Living Well" section of our webpage at cpr.bu.edu or contact Stephanie Cummings at (617) 353-3549 or stephc13@bu.edu.

Date Sent:

PART 1: REQUEST SERVICES

Please check all of the services that you would like to request:

☐ **Recovery Education Program**
☐ **Individual Services – Supported Education**
☐ **Individual Services – Vocational**
☐ **Individual Services – Health Promotion**

PART 2: CONTACT INFORMATION

Name:

[Last Name] **[First]** **[Middle Initial]**

Address:

[Street] **[Apartment/Suite Number]**

[City/Town] **[State]** **[Zip Code]**

Phone:

[Home] **[Cell]**

Email:

Date of Birth:

[MM/DD/YYYY]

PART 3: CURRENT MEDICAL & PSYCHIATRIC CONDITIONS

Current Medical Conditions

☐ AIDS/HIV	☐ Heart Attack/Failure
☐ Cognitive	☐ Hemophilia
☐ Anaphylaxis	☐ Hepatitis _____ (A,B or C)
☐ Anemia	☐ High Blood Pressure
☐ Angina	☐ High Cholesterol
☐ Arthritis/Gout	☐ Irregular Heartbeat
☐ Artificial Heart Valve	☐ Kidney Problems
☐ Asthma	☐ Liver Disease
☐ Blood Disease	☐ Low Blood Pressure
☐ Breathing Problem	☐ Lung Disease
☐ Cancer	☐ Osteoporosis
☐ Chest Pain	☐ Stomach/Intestinal Disease
☐ Clinical Obesity	☐ Stroke
☐ Convulsions	☐ Tuberculosis
☐ Diabetes	☐ Ulcers
☐ Dizziness or Fainting Spells	☐ Other:_____
☐ Ear Problems/Hearing Loss	☐ Other:_____
☐ Emphysema	☐ Other:_____
☐ Epilepsy or Seizures	☐ Other:_____
☐ Eye Problems	☐ Other:_____

Current Psychiatric Conditions

☐ Alcohol/Substance Abuse	☐ Panic Disorder
☐ Anxiety Disorder	☐ Personality Disorder (Borderline, Antisocial, etc.)
☐ Asperger's Disorder	☐ Post-Traumatic Stress Disorder (PTSD)
☐ Attention Deficit/Hyperactivity Disorder (ADHD/ADD)	☐ Schizophrenia
	☐ Seasonal Affective Disorder (SAD)
☐ Autism	☐ Sexual & Paraphilic Disorder
☐ Bipolar Disorder	☐ Sleep & Wake Disorder (Insomnia, Narcolepsy, etc.)
☐ Depression	☐ Other:_____
☐ Dissociative Disorder	☐ Other:_____
☐ Hoarding Disorder	☐ Other:_____
☐ Hypochondriasis	☐ Other:_____
☐ Obsessive-Compulsive Disorder (OCD)	☐ Other:_____

PART 4: DEMOGRAPHIC SURVEY

1. **What is your gender identity?**
   - ☐ Female
   - ☐ Male
   - ☐ Female to male transgender (FTM)
   - ☐ Male to female transgender (MTF)
   - ☐ Other (please specify): _____

2. **What is your age?** _____

3. **What is your date of birth?** _____ (MM/DD/YYYY)

4. **What is your race?**
   - ☐ White
   - ☐ Hispanic or Latino
   - ☐ Black or African American
   - ☐ Native American or American Indian
   - ☐ Asian/Pacific Islander
   - ☐ Other (please specify): _____
   - ☐ Prefer not to answer

5. **What is the highest degree or level of school you have completed?**
   - ☐ No schooling
   - ☐ Less than High School
   - ☐ High School Diploma/GED
   - ☐ Some College
   - ☐ 2-Year College Degree (Associates)
   - ☐ 4-Year College Degree (BA, BS)
   - ☐ Master's Degree
   - ☐ Doctorate Degree
   - ☐ Professional Degree (MD, JD)
   - ☐ Prefer not to answer

6. **What is your current marital status?**
   - ☐ Single/Never Married
   - ☐ Married
   - ☐ Separated
   - ☐ Divorced
   - ☐ Widowed
   - ☐ Prefer not to answer

7. **What is your current employment status?**
   - ☐ Employed Full-time (40+ hours per week)
   - ☐ Employed Part-time (1-39 hours per week)
   - ☐ Not Employed, Looking for Work
   - ☐ Not Employed, Not Looking for Work
   - ☐ Retired
   - ☐ Disabled, Not Able to Work
   - ☐ Prefer not to answer

8. **What is your current religious affiliation?**
   - ☐ Christian
   - ☐ Jewish
   - ☐ Buddhist
   - ☐ Muslim
   - ☐ Hindu
   - ☐ Unaffiliated
   - ☐ Other (please specify): _____
   - ☐ Prefer not to answer

9. **What is your current household income?**
   - ☐ Under $10,000
   - ☐ $10,000 - $19,999
   - ☐ $20,000 - $29,999
   - ☐ $30,000 - $39,999
   - ☐ $40,000 - $49,999
   - ☐ $50,000 - $ 74,999
   - ☐ $75,000 - $99,999
   - ☐ $100,000 - $150,000
   - ☐ Over $150,000
   - ☐ Prefer not to answer

PART 5: EMERGENCY CONTACT INFORMATION

In case of a *medical emergency*, please contact the following person:
Name:
Relationship:
Address:
Phone (Primary):
Phone (Secondary):

In case of a *personal emergency*, please contact the following person:
Name:
Relationship:
Address:
Phone (Primary):
Phone (Secondary):

PART 6: PROFESSIONAL SUPPORTS

Primary Care Physician
Name:
Medical Facility/Clinic/Program:
Address:
Phone (Primary):
Phone (Secondary):

PART 6: PROFESSIONAL SUPPORTS CONTINUED

Psychiatrist
Name:
Medical Facility/Clinic/Program:
Address:
Phone (Primary):
Phone (Secondary):

Therapist
Name:
Medical Facility/Clinic/Program:
Address:
Phone (Primary):
Phone (Secondary):

Dentist
Name:
Medical Facility/Clinic/Program:
Address:
Phone (Primary):
Phone (Secondary):

PART 7: INTERESTS & GOALS

Please explain your interest(s) in Recovery Services at the Center:

Please explain your recovery goals and discuss what kind of help and support you think you will need to accomplish those goals:

PART 8: MEDICAL & PSYCHIATRIC INFORMATION FORM

Instructions for Part 8:

The Medical & Psychiatric Information Form on the next page (page 8) needs to be completed by your primary care physician and/or psychiatrist, and faxed to Stephanie Cummings at (617) 353-7700. An electronic version of the form is available on the "Living Well" section of our webpage at cpr.bu.edu.

We prefer if your Medical & Psychiatric Information Form was faxed with the rest of your Student Application Packet.

(See Next Page for Medical & Psychiatric Information Form)

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MEDICAL & PSYCHIATRIC INFORMATION FORM

Instructions: Please fax completed form to Fallon Fernandes at (617) 353-7700.

Patient's Name:

[Last] **[First]** **[Middle Initial]**

Physician/Psychiatrist's Name:

[Last] **[First]** **[Middle Initial]**

Medical Facility/Clinic/Program:

Date of Last Physical Exam:

Does patient have any physical limitations that would prevent him/her from participating in an exercise course?:
☐ **Yes** ☐ **No**

AXIS I*		Clinical Disorders
AXIS II		Personality Disorders/MR
AXIS III*		General Medical Conditions (write in diagnoses)
AXIS IV		Psychosocial/Environmental Problems
AXIS V		Global Assessment of Functioning

***Required Fields**

1. **Weight: _____ lbs.**
2. **Height: _____ ft. _____ in.**
3. **BMI: _____**
4. **Total Cholesterol: _____ HDL _____ LDL _____ TRI**
5. **Glucose: _____**

Psychiatric Medication(s)

Other Medication(s)

Please List Any Restrictions/Recommendations:

Physician/Psychiatrist's Signature: **Date:**