TO BE FILLED OUT BY PARENT/LEGAL GUARDIAN OR CARETAKER

PATIENT'S NAME_____

PATIENT LIVES AT: HOME_____FACILITY_____

PATIENT'S ADDRESS_____

_____

TELEPHONE #_____

FATHER'S NAME_____

MOTHER'S NAME_____

MOTHER'S MAIDEN NAME_____

PATIENT'S DATE OF BIRTH: MONTH___DAY___YEAR___

EDUCATIONAL LEVEL_____

EMPLOYMENT STATUS_____

SOCIAL SECURITY #_____

MARITAL STATUS: single__married__divorced__widowed__

CITIZEN OF: USA___OTHER_____

DEVELOPMENTAL DIAGNOSIS_____

AGE OF ONSET: Birth_____ Other age_____

STATE OF HEALTH: GOOD___FAIR___POOR_____

DATE OF LAST MEDICAL EXAM_____

PHYSICIANS NAME_____

TELEPHONE #_____

HAS PATIENT EVER BEEN HOSPITALIZED: YES___NO___

WHY_____

WHERE_____

HISTORY OF SEIZURES: YES___NO___

TYPE OF SEIZURES:_____

PRESENTLY CONTROLLED: YES___NO___

ALLERGIES:(if none please state none)_____

_____

_____

_____

DATE_____ RACE_____ SEX: M_____F_____

LANGUAGE SPOKEN_____

WEIGHT_____ HEIGHT_____

GUARDIAN'S NAME_____

GUARDIAN'S ADDRESS_____

_____

_____

TELEPHONE # HOME_____

TELEPHONE # WORK_____

DATE OF GUARDIANSHIP APPOINTMENT_____

TYPE OF GUARDIANSHIP_____

GRANT_____

PHYSICAL COORDINATION: (PLEASE CHECK ONE

SITTING: NONE__ POOR__ FAIR__ GOOD__

STANDING: NONE__ POOR__ FAIR__ GOOD__

WALKING: NONE__ POOR__ FAIR__ GOOD__

BALANCE: NONE__ POOR__ FAIR__ GOOD__

GRASPING: NONE__ POOR__ FAIR__ GOOD__

SPEECH: NONE__ POOR__ FAIR__ GOOD__

VISION: NONE__ POOR__ FAIR__ GOOD__

HEARING: NONE__ POOR__ FAIR__ GOOD__

IS PATIENT IN WHEEL CHAIR YES___ NO___

PATIENTS ABILITIES: (PLEASE CHECK ONE

FEEDS SELF: YES___NO___WITH HELP___

DRESSES SELF: YES___NO___WITH HELP___

TOILET TRAINED YES___NO___WITH HELP___

MEDICATION IN USE: (if none, please state none)

NAME DOSAGE TIMES PER DAY

_____

_____