

Pre-Service Questionnaire

Consumer's Name: _____ **Sex:** _____ **Age:** _____

Address: _____

City: _____ **County:** _____

Phone: _____ **Work:** _____ **Cell:** _____

Email: _____

Consumer Employment/School: _____

Referring Person/Agency: _____

Address: _____

City: _____ **County:** _____

Phone: _____ **Fax:** _____ **Email:** _____

What is expected from the service?

Diagnosis/Disability:

Please check and describe all items that apply:

Mobility: Ambulatory Nonambulatory

Device? Y N Please explain:

Seating and positioning issues Specify: _____

Gross Motor limitations Specify: _____

Fine Motor limitations Specify: _____ Hand Dominance: _____

Endurance limitations Specify: _____

Strength limitations Specify: _____

Communication issues Specify: _____

_____ Primary Language _____ Secondary: _____

Visual issues Specify: _____ Corrective Lenses _____

Hearing issues Specify: _____ Hearing Aids R L B

Cognitive issues Specify: _____

Literacy issues Specify: _____

Writing issues Specify: _____

Favorite Activities/Interests/Hobbies: (special toys, television shows, movies, etc.)

Describe any significant behavior, both positive and negative:

Are there significant factors about the individual's strengths, learning style, coping strategies or interests that should be considered?

Does the individual display a change in performance at different times of the day?

Notes: