ASPIRE Center for Learning and Development
Specializing in autism spectrum disorders

**OFFICE USE ONLY**

Day of first Appointment: _____

Clinician: _____

# CLINIC INFORMATION FORM (ADULT)

## GENERAL INFORMATION

| NAME: | DOB: | CURRENT AGE: | ☐ MALE ☐ FEMALE |
|---|---|---|---|
| HOME ADDRESS: | | HOME PHONE: | |
| | | CELL PHONE: | |
| WHO MAY WE THANK YOU REFERRING YOU? | | EMAIL: | |

## INFORMATION ON PARENT/LEGAL GUARDIAN//FAMILY MEMBER RESPONSIBLE FOR THE INDIVIDUAL (*if applicable*)

| NAME (S): | RELATIONSHIP: |
|---|---|
| ADDRESS *(if different than above)*: | PHONE *(if different than above)*: |

IS THIS PERSON THE LEGAL GUARDIAN? ☐ YES ☐ NO

HAS THIS PERSON BEEN NOTIFIED OF INTEREST IN CLINIC SERVICE(S)? ☐ YES ☐ NO (*please explain*):

## SCHOOL / WORK INFORMATION

| SCHOOL: | YEAR: | ☐ P/T ☐ F/T | SERVICES: |
|---|---|---|---|

| EMPLOYMENT: ☐ N/A ☐ YES ☐ NO | EMPLOYER: | JOB TITLE: | HOURS WORKED/WEEK: |
|---|---|---|---|

## CURRENT MEDICAL INFORMATION

| PRIMARY PHYSICIAN AND CONTACT INFORMATION: | CURRENT MENTAL HEALTH SERVICE PROVIDER(S) AND CONTACT INFORMATION: |
|---|---|

MEDICATIONS: ☐ NO ☐ YES

PLEASE SPECIFY TYPE, DOSAGE, AND REASON FOR ADMINISTRATION:

ALLERGIES:

## CLINICAL INFORMATION

REASON FOR REQUEST (*primary presenting problem[s]*):

**SERVICE(S) OF INTEREST (✓ *all that apply):***

| | | |
|---|---|---|
| ☐ DIAGNOSTIC EVALUATION | ☐ PARENT TRAINING | ☐ SCHOOL CONSULTATION |
| ☐ CONSULTATION | ☐ GROUP THERAPY/SOCIAL SKILLS | ☐ TRANSITION PLANNING |
| ☐ INDIVIDUAL THERAPY | ☐ THERAPEUTIC RECREATION | ☐ HOME CONSULTATION |
| ☐ FAMILY THERAPY | ☐ COMMUNITY OUTINGS | ☐ OTHER: |

ADDITIONAL INFORMATION YOU WISH TO SHARE: