ASPIRE Center for Learning and Development
Specializing in autism spectrum disorders

CLINIC INFORMATION FORM (CHILD)

GENERAL INFORMATION

CHILD'S NAME:	DOB:	Current Age:	☐ MALE ☐ FEMALE
HOME ADDRESS:			HOME #:
			CELL #:
			EMAIL:

INFORMATION ON PARENT/LEGAL GUARDIAN//FAMILY MEMBER RESPONSIBLE FOR THE INDIVIDUAL

PARENT NAME (S):	RELATIONSHIP:
ADDRESS *(if different than above)*:	PHONE # *(if different than above)*:

SCHOOL INFORMATION

SCHOOL:	PHONE#:	GRADE:	CLASSROOM TYPE:	IEP? YES ◯ NO ◯

CURRENT MEDICAL INFORMATION

PRIMARY PHYSICIAN:	OFFICE PHONE #:

MEDICATIONS: ◯ NO ◯ YES, SPECIFY TYPE DOSAGE AND REASON FOR ADMINISTRATION:

ALLERGIES:

SERVICE(S) INFORMATION

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

SERVICE(S) *(place a ✓ in the box for each service requested)*

DIAGNOSTIC EVALUATION	☐	**PARENT TRAINING**	☐
CONSULTATION	☐	**SCHOOL CONSULTATION**	☐
INDIVIDUAL THERAPY	☐	**TRANSITION PLANNING**	☐
GROUP THERAPY	☐	**HOME CONSULTATION**	☐
SOCIAL SKILLS GROUP	☐	**OTHER:**	
COMMUNITY OUTING	☐	_____	

Other important information you wish to share:

CLINIC USE - PERSON REVIEWING ADMISSION INFORMATION:	**TITLE:**	
	DATE:	