Assistive Technology Consultation Intake Form

Patient's Name _____ Date _____

Parents' Names _____

Address _____ Apt _____

City/State/Zip _____

Telephone (home) _____ Other _____ work☐ cell☐

Birthdate _____

MEDICAL BACKGROUND

What is the diagnosed disability?

_____

Describe the disability and how it affects performance as a student.

_____

_____

List any medications taken and their side effects.

_____

_____

Are there any long-term medical problems? If yes, please explain.

_____

_____

Describe any serious illnesses/injuries that currently affect you.

_____

_____

Assistive Technology Services:

Has there been any previous assistive technology consultation/evaluation? If so, from where, when and by whom? What did they recommend?

_____

_____

What is your primary area of concern that may benefit from assistive technology? Check all that apply:

- ☐ Reading
- ☐ Writing
- ☐ Learning/studying/spelling
- ☐ Organization
- ☐ Communication
- ☐ Physical skills that limit computer access
- ☐ Other _____

What do you hope will be the outcome of this consultation?

_____

_____