



Name		DATE			
DOB AGE DEVELOPMENTAL AGE		DIAGNOSIS			
FAMILY					
Parents					
Sibs	older	younger			
Other significant people					
LIKES & DISLIKES, FAVORITES & FEARS					
 Foods/Restaurants/Music/Books/Characters/Activities/People					
 Fears/Dislikes/Upset by					
FOOD & DRINK					
Drink container	open cup	bottle	sippy cup	straw	brings own
Food or drink restrictions					
Preferences					
TOILET & HYGIENE					
Independent		Wears diaper/pull-ups/other			
Any special instructions?					

**CURRENT EDUCATIONAL SETTING OR DAYTIME ACTIVITIES**

**HEALTH & SAFETY**

**Seizures**

**Medications**

**Other health issues**

**Attitudes and Behaviors –**

Positives

Negatives

**How can we redirect inappropriate behavior?**

**COMMUNICATION**

Verbal or Non-verbal?

Understands directions?

Reads/Writes?

Uses sign language?

**YOU DIDN'T ASK, BUT I WANT YOU TO KNOW THIS, TOO**