

Diagnostic Questionnaire for Adult Client
(age 18 and over who are their own guardian)

Adult Client's Name: _____ Date Completed: _____

Age: _____ Date of Birth: _____

Street or Mailing Address: _____ Suite or Apt #: _____

City: _____ State: _____ Zip Code: _____ County: _____

Email: _____ Primary Phone: _____

Phone 1: _____ Phone 2: _____

1) Describe a typical day: (daily routines, where you go, who you see, leisure and work time, meals, etc.)

2) What made you think that you would like to pursue an evaluation through TEACCH?

3) Give one or two examples of a difficulty you have (if any) in each of the following areas:

SOCIAL INTERACTION

COMMUNICATION

DIFFICULTIES WITH CHANGE

SENSORY ISSUES

4) As well as you can remember, did you experience these problems when you were younger? If so, please describe an example of social or communication difficulties you had.

As a child:

As an adolescent:

5) What are your best skills?

6) What are some activities you enjoy?

7) What things are most challenging for you?

8) What aspects of your life would you like to improve? *(e.g., work, family, friends, etc.)*

9) Is there anything that you think is important for us to know?

Please send the completed form to your local TEACCH Center