PARENTS IN ACTION, INC. Family Profile

Date:

Family Information

Family Name:

Mother's Name:

Home Phone:
Cell Phone:
Work Phone:
E-mail:
Occupation:
Company Name:

Home Address:

Father's Name:

Home Phone:
Cell:
Work:
E-mail:
Occupation:
Company Name:

Home Address:

Non- affected Siblings (list with age):

Name: Age:
Name: Age:
Name: Age:
Name: Age:

Other extended family involved (i.e. Grandparents):

Siblings willing to speak to the media:

Child Affected by Autism Spectrum Disorder

Name: Age: Age Diagnosed:

Diagnosis (Where on the Spectrum):

What were the signs that lead you to believe that your child had a developmental disorder?

How your child communicates (i.e. verbal, sign language):

Types of therapy your child receives:

Name of Therapy:	Days per week:
Name of Therapy:	Days per week:
Name of Therapy:	Days per week:

What treatment/therapy have you found most affective?

Primary care provider to affected child:

Phone:

E-mail:

Other extended family involved (i.e. Grandparents):

Approximate yearly cost (i.e. medical attention/care giving):

Do you have Medicaid?

Do you have Medicaid Waiver? If not, are you on the Waitlist?

Does health insurance cover any therapies?

What is your child's story?

How has Autism affected your other children?

If you could speak to the media regarding your family's situation with Autism Spectrum Disorder, what topic would you focus on?

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