

# Consumer Informational Form

Consumer Name: \_\_\_\_\_

Consumer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

County of Residence: \_\_\_\_\_

Consumer social security number \_\_\_ - \_\_\_ - \_\_\_\_\_ Consumer Date of Birth: \_\_\_/\_\_\_/\_\_\_

Is this consumer an active client of the Regional Center? \_\_\_yes \_\_\_no

Regional Center Worker: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Consumer Race: \_\_\_\_\_ Consumer gender: \_\_\_\_\_

Did this person's disability manifest itself before age 19?  Yes  No

Recent Diagnosis attached:  Yes  No

Consumer Diagnosis: (Mark all that apply)

Autism  Learning Disability  Cerebral Palsy  Mental Retardation  Epilepsy  Head Injury

Other Diagnosis:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Check the substantial functional limitation in 2 or more of the following areas of major life activities.

Capacity for independent Living  Learning  Self Care  Mobility  Receptive/Expressive Language

Self Direction or economic self sufficiency

Other Agencies involved with the family:

\_\_\_\_\_  
\_\_\_\_\_

Legal Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Numbers Home: \_\_\_\_\_ Work: \_\_\_\_\_