



CHDR Research Participant Form

Today's Date: ____/____/____

Participant Name: _____

Gender: ____ Male ____ Female

Date of Birth: ____/____/____

Current Age: _____

Primary Language: ____ English ____ Spanish ____ Other: _____

Hearing Loss? ____ Yes ____ No

Vision Problems? ____ Yes ____ No

School Program: _____ School Grade: _____
(e.g., Special Education, Life Skills, mainstreamed, resource)

Current Diagnosis (Check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Learning Disabled | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asperger's Disorder | <input type="checkbox"/> Conduct Disorder | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> PDD-NOS | <input type="checkbox"/> Mentally Retarded | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Other: _____ | |

Previous IQ Testing? ____ Yes ____ No Results: _____

Have you been seen before at MSI? ____ If yes, By whom: _____

Was it for research? ____ Yes ____ No

Current Medications: _____

Does participant have braces or other internal metal? ____ Yes ____ No

Parent/Guardian Name: _____ Relationship: _____

Home Address: _____

Home Phone Number: _____ Fax Number: _____

Work Phone Number: _____ Cell Phone Number: _____

E-mail Address: _____