

Assistive Technology Evaluation Questionnaire

Assistive Technology Services, Advancing Opportunities

(This section to be completed by: Parent/Guardian)-**Please use black ink**

Student Name:	District:	Date:
Parent / Guardian Name:		
E-mail:		
Sibling Names:	Age	

Directions: Please respond to relevant questions, and skip any questions that you do not have an answer to. Return Questionnaire to: Child Study Team Case Manager

What would you like to see your child do that he or she cannot do now?

Definition of Assistive Technology: "Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities."

What assistive technology, supports, or strategies have you already tried:

What are your child's interests?

Sports	Music
Book	Magazines
Pets	Television

Games	Others:
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What type of computer equipment is available at home?

Microsoft 98 Me XP Not sure

Macintosh OS9 OS 10 Other Not Sure

Computer is ____ years old.

Who is responsible for technical support for the family computer?
Where is the computer located in the home?

What does your child use the computer for?

- | | | | |
|---|---|---|--------------------------------|
| <input type="checkbox"/> Homework: | <input type="checkbox"/> 1-2 times a week | <input type="checkbox"/> 3-4 times a week | <input type="checkbox"/> Daily |
| <input type="checkbox"/> Games: | <input type="checkbox"/> 1-2 times a week | <input type="checkbox"/> 3-4 times a week | <input type="checkbox"/> Daily |
| <input type="checkbox"/> Internet / Email: | <input type="checkbox"/> 1-2 times a week | <input type="checkbox"/> 3-4 times a week | <input type="checkbox"/> Daily |
| <input type="checkbox"/> Instant Messaging: | <input type="checkbox"/> 1-2 times a week | <input type="checkbox"/> 3-4 times a week | <input type="checkbox"/> Daily |

Please include any other important fact that you would like to share about your child:
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