Parent Questionnaire

ASD (Autism Spectrum Disorder)

Child's Name _____

Date of Birth _____/_____/_____

Parents (or) Caregiver_____

(Space Intentionally Blank)

ASD Patient Information Form

Patient Name _____ **DOB**_____ **Today's Date** _____

Person completing form _____ **Relationship** _____

Daytime Phone _____ **Work Phone** _____

Current School _____ **Grade** _____

Teacher Name _____ **Phone** _____

IMPORTANT: Please send these completed forms along with copies of report cards from recent grades completed, all psychological reports, and any counseling evaluations. Please complete all information. After reviewing this information, our office will contact you for an appointment.

Present placement of child (please ✓ appropriate box)	Adult with whom child is living >50% of the time	Adults not living in the home, but involved with child
Biological mother		
Biological father		
Step-mother		
Step-father		
Adoptive mother		
Adoptive father		
Relative (specify)		
Other (specify)		

Briefly state your concerns: _____

_____

_____

_____

_____

_____

_____

_____

School History

1 . Please list schools attended in chronological order, starting with the most recent:

School Grades Attended City, State

_____

_____

_____

_____

_____

2. Please comment on your child's *academic* progress within each of these grade levels by writing ***Good, Fair, Poor, or Not Applicable (N/A)*** in the appropriate boxes.

	Pre-School	Kinder-garten	Grades 1-3	Grades 4-5	Grades 6-8	Grades 9-12
Relationship with peers						
Relationship with siblings						
Relationship with parents						
Relationship with teachers						
Overall school performance						
Behavior in school						
Participation in after school activities or sports						
Organizational skills						
Disrupting class						
Following directions/rules						
Homework completion						
Completing chores at home						

3. To the best of your knowledge, at what grade level is your child functioning?
Reading _____ Spelling _____ Math _____
4. Present class placement (circle): regular class *or* special class (if so, specify what kind of special class): _____

_____

_____

5. Has your child ever been in any type of special education program, and if so, for how long?

Yes	No	Duration	Kind of special education program
			Learning disabilities class
			Behavioral disorders class
			Skills class led by social worker or school counselor
			Resource room
			Private tutoring or one-on-on aide
			Other (please specify):

6. Have any additional educational modifications been attempted?

Yes	No	When	Type of instructional modification
			Private tutoring
			Behavioral modification program
			Daily or weekly progress report cards
			Class note taker assistance
			Books on tape for school texts
			Training and usage of computer

7. Please answer the following questions

Yes	No	When	Has your child ever…
			Been suspended from school?
			Been expelled from school?
			Repeated a grade?
			Had difficulty verbally expressing him/herself?
			Had difficulty understanding spoken directions?
			Had any speech difficulties or impediments?
			Had any speech or occupational therapy?

8. Please list any academic testing, psychological evaluations and medical evaluations previously done for your child's learning problems (BASC, STAT, MCHAT, ASQ, MAT, WISC-R, CPT, WRAT, etc.).

_____

_____

_____

_____

9. How would you rate your child's overall level of intelligence compared to his/her peers?

_____

_____

_____

Current Behavioral Concerns

1. What concerns do you have about your child's behavior? _____

Mood & Anxiety Concerns

- What concerns do you have about your child's emotions or moods?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

- Many children with ASD appear overly **anxious.** Which of the following are *significant* problems at the present time?

Yes	No	
		Unrealistic worry about future events
		Worries excessively about school work
		Blames self for things that are not his fault
		Worries excessively about how he does at sports
		Worries excessively about bad world events
		Worries excessively about upcoming events
		Worries excessively about getting sick or dying
		Very self-conscious or needs excessive reassurance
		Frequent complaints of body aches and pains
		Very scared to meet new people or social situations
		Frequent nightmares

When did these problems begin? Specify age:_____

Please describe **YES** answers above:

Other comments:

4. Many children with ASD appear **depressed.** Which of the following are *significant* problems at the present time?

Yes	No	
		Sad or irritable most of the day, nearly every day
		Diminished pleasure in activities that he/she used to like
		Change in appetite, or unexplained weight gain or loss
		Trouble falling asleep
		Excessively sleeping nearly every day
		Fatigue or loss of energy
		Agitated, on edge
		Feelings of worthlessness or excessive guilt
		Trouble concentrating, more forgetful than usual
		Suicidal thoughts or attempts

When did these problems begin? Specify age:_____

Please describe **YES** answers above:

Other comments:

6. Some children with ASD experience unusual **compulsions or tics.** Which of the following are *significant* problems at the present time?

Yes	No	
		Unusual rituals, obsessions (recurrent thoughts, feelings, ideas, or sensations that your child cannot get out of his/her mind) and/or compulsions (recurrent behaviors/actions such as counting, checking, twirling, etc.)?
		Fears of becoming aggressive toward others
		Religious obsessions
		Obsession with germs, diseases, or hygiene
		Obsessions about being on time or being late
		Obsessions about following rules
		Excessive hand washing
		Checking locks, ovens, etc.
		Arranging objects in certain ways
		Obsessively counting objects
		Saying repetitive words to self
		Motor tics (eg., blinking, squinting, facial jerking, shoulder shrugging)
		Vocal tics (eg., sniffing, clearing throat, habit cough, humming, noises)
		Biting lips or chewing on nails

7. When did these problems begin? Specify age:_____

Please describe **YES** answers above:

Other comments:

Social Interactions

1. What concerns do you have about your child's social interactions with other children?

_____

_____

_____

_____

_____

_____

2. Please describe how your child gets along with brothers and sisters?

_____

- Does your child primarily play with children:
  own age? _____ older? _____ younger? _____

Yes	No	Does your child…
		Respond to positive rewards?
		Understand or use body language to express him/herself?
		Engage in imaginary play?
		Have abnormal or unusual reactions to objects touching him/her?
		Exhibit extreme reluctance to take care of his/her personal hygiene?
		Have friends with whom he/she plays regularly?
		Talk to people who are not there?
		Believe he/she is someone else?
		Believes he/she hears voices talking to him/her?
		See things that are not there?

Social History

1. Are you and the child's father (mother) married? If so, how long?

_____

2. Is your current spouse/significant other the child's biological parent?

_____

3. How would you describe your family household functioning (circle all that apply)?

Warm	Friendly	Loving	Caring	Stress-free
Supportive	Chaotic	In Crisis	Unstable	Stressful

Other: _____

- Please list all people living in the child's household, and their relationship to the child:

Person's name	Age	Relationship to the child

- Father's job/place of employment: _____

  Mother's job/place of employment: _____

  Father's highest level of education: _____

  Mother's highest level of education: _____

6. Types of discipline you use with your child:

Yes	**No**	
		Verbal reprimands or corrections
		Time out (isolation)
		Loss of privileges
		Rewards for positive behavior
		Ignoring negative behavior
		Physical punishment (eg., spanking)
		Give in to child
		Avoidance of child

1. What percentage of the time does your child comply with ***initial*** commands? _____
2. What percentage of the time does your child ***eventually*** comply with commands? _____
3. Have any of the following stressful events occurred within the past 2 years?

Yes	No	
		Parents divorced or separated
		Change in primary caretaker
		Caretaker has new live-in significant other
		Family accident or illness
		Death in the family
		Parents changed or lost job
		Changed schools
		Family moved
		Family financial problems
		Severe psychological trauma (specify):
		Other (please specify):

4. What are your child's main hobbies and interests? _____

_____

5. What does your child **enjoy** doing most? _____

_____

6. What does your child **dislike** to do most? _____

_____

7. What are your child's areas of greatest accomplishment? _____

_____

8. How many hours a day does your child spend:

   On the computer: _____ Watching TV: _____

   Playing video games: _____ Reading: _____ Playing outdoors: _____

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Developmental Screen

Pregnancy

1. 1. Mother's age when child was born: _____ Duration of pregnancy (weeks): _____
2. Any health problems or infections with mom during pregnancy? If so, specify:

   _____

   _____
3. _____

   _____
4. Medications taken by mother during pregnancy:

   _____

   _____
5. Smoking by mother during pregnancy? _____if so, how many packs per day? _____
6. Drug use by mother during pregnancy? _____ If so, which drugs? _____

   _____

   _____
7. Alcohol use during pregnancy? _____If so, how much/what type? _____

   _____

Father:

Drug use by father at time of conception? _____ If so, which drugs? _____

_____

Delivery/Nursery Course

1. Type of labor (circle): spontaneous (or) induced
2. Type of delivery (check✓): normal/vaginal ___ breech ___ caesarian/c-section ____
3. Birth weight _____lbs _____oz
4. Complications during delivery or afterwards? _____

_____

- Did infant require oxygen for more than 4 hours after delivery? _____
- Did the infant have jaundice? _____ Did he/she require phototherapy? _____
- Did the infant have infection? _____
- Number of days infant was hospitalized after delivery: _____

5. Any health complications in the baby after birth? _____

_____

Infancy/Toddler Period

Yes	No	
		Were there feeding problems during early infancy (0-4 months of age)?
		Was the baby difficult to cuddle?
		Was the baby colicky or more fussy than usual?
		Were there sleep pattern problems during early infancy?
		Were there problems with the infant's alertness?
		Did the child have any congenital problems?
		Was the child a difficult baby (did not calm easily or follow a schedule, excessive crying)?
		Was the baby excessively restless?
		Did the toddler behave poorly with others?
		Did the toddler throw excessive temper tantrums?
		Was the toddler insistent and demanding?
		Was the toddler extremely active, into everything?
		Was the child accident prone or clumsy?

Developmental Milestones

	At what age did the child smile?
	At what age did the child roll over?
	At what age did the child sit up?
	At what age did the child crawl?
	At what age did the child walk?
	At what age did the speak single words (besides dada/mama)?
	At what age did the child string two or more words together?
	At what age did the child speak in sentences?
	At what age did the child achieve bladder control?
	At what age did the child learn to ride a tricycle?
	At what age did the child ride a bicycle without training wheels?
	At what age did the child button clothing?
	At what age did the child tie shoelaces?
	At what age did the child name colors?
	At what age did the child say the alphabet?
	At what age did the child begin to read?

Medical History

Concerns

1. Rate your child on the following:

Good	Average	Poor	
			General health
			Hearing
			Vision
			Walking
			Running
			Throwing
			Catching
			Shoelace tying
			Buttoning
			Handwriting
			Athletic ability

2. Has your child had any chronic health problems (e.g., asthma, heart condition, diabetes, etc.)? If so, please specify (include overnight hospitalizations): _____

_____

_____

_____

(IF YES) What age was the onset of any chronic illness?

_____

_____

3. Has your child had any of the following illnesses:

Yes	No	
		Mumps
		Chicken pox
		Measles
		Whooping cough
		Scarlet fever
		Pneumonia
		Encephalitis (brain infection)
		Meningitis
		Ear infections
		Lead poisoning
		Seizures (convulsions)

4. Has your child experienced any of the following:

Yes	No	
		Heart murmur
		Heart rhythm problem (arrhythmia)
		Heart surgery
		Unexplained chest pain with exercise
		Shortness of breath with exercise
		Unexplained inability to keep up with other kids during exercise
		Unexplained racing heart for no reason
		Palpitations (skipping heart beats) for no reason
		Sudden collapse for no reason
		Fainting or loss of consciousness

. 5. Has your child had any accidents resulting in the following:

Yes	No	
		Broken bones
		Severe lacerations
		Head injury, coma, amnesia
		Severe bruises
		Stomach pumped (poisoning)
		Eye injury
		Sutures (stitches)

5. Is there any suspicion of alcohol or drug use? _____

_____

6. Is there any history of trauma?

_____

_____

7. Does your child have any problems sleeping? _____

_____

8. Is there a TV in your child's bedroom? YES / NO Does the child sleep by himself? YES / NO
9. What is your child's bedtime? _____ when does he/she actually fall asleep? _____
10. What time does your child wake on school days? _____ On weekends? _____
11. Does your child snore? YES / NO does your child's sleep restless? YES / NO
12. Does your child have any problems with bed-wetting or having bowel movements in his/her pants?

_____

_____

13. Does your child have any symptoms of disordered eating? _____

_____

Treatment History

1. List names and contact information of all other professionals who have seen your child for these concerns:

   Name: _____ Contact Info: _____

   _____

   Name: _____ Contact Info: _____

   _____

   Name: _____ Contact Info: _____

   _____

   Name: _____ Contact Info: _____

   _____

2. Have you tried any of the following interventions for your child's behavior (please describe)?

Dietary changes: _____ Supplements/Vitamins: _____

Natural remedies: _____

3. Has your child ever received any of the following medications for ASD:

Yes	Duration	Good effects observed?	Side effects or problems?	Medication
				Methylphenidate/Ritalin
				Concerta
				Focalin
				Dextroamphetamine/Dexedrine
				Adderall/Adderall XR
				Antidepressants
				Mood stabilizers
				Anticonvulsants
				Other:

4. Has your child ever received any of the following forms of psychological treatment?

Yes	No	Duration	
			Individual psychotherapy or counseling
			Group psychotherapy or counseling
			Family therapy with child
			Inpatient evaluation and treatment
			Residential treatment (including drug and alcohol)

Family History

Father's Family History

Please check whether anyone on father's side of the family has had the following problems:

Relationship to Child	Father	Paternal Grandmother	Paternal Grandfather	Paternal Aunts	Paternal Uncles
Problems with aggression, defiance, and oppositional behavior as a child					
Problems with attention, hyperactivity, and impulse control as a child					
Learning disabilities or poor school performance					
Failed to graduate from high school					
Mental retardation					
Autism or Pervasive Developmental Disorder					
Psychosis or schizophrenia					
Hospitalization in a psychiatric or mental hospital					
Depression greater than 2 weeks					
Anxiety disorder					
Obsessive Compulsive Disorder					
Bipolar or Manic-Depressive Disorder					
Tics or Tourette's Syndrome					
Alcohol abuse					
Substance abuse					
Antisocial behavior (assaults, thefts, etc.)					
Arrests or jail time					
Perpetrator of physical abuse					
Perpetrator of sexual abuse					
Victim of physical abuse					
Victim of sexual abuse					
Heart rhythm problems/arrhythmias					
Sudden death due to heart problem under age 50					
Congenital heart disease					

Please describe any **YES** answers above (e.g., what diagnoses or treatments were given):

_____

_____

_____

_____

_____

_____

_____

Mother's Family History

Please check whether anyone on mother's side of the family has had the following problems:

Relationship to Child	Mother	Maternal Grandmother	Maternal Grandfather	Maternal Aunts	Maternal Uncles
Problems with aggression, defiance, and oppositional behavior as a child					
Problems with attention, hyperactivity, and impulse control as a child					
Learning disabilities or poor school performance					
Failed to graduate from high school					
Mental retardation					
Autism or Pervasive Developmental Disorder					
Psychosis or schizophrenia					
Hospitalization in a psychiatric or mental hospital					
Depression greater than 2 weeks					
Anxiety disorder					
Obsessive Compulsive Disorder					
Bipolar or Manic-Depressive Disorder					
Tics or Tourette's Syndrome					
Alcohol abuse					
Substance abuse					
Antisocial behavior (assaults, thefts, etc.)					
Arrests or jail time					
Perpetrator of physical abuse					
Perpetrator of sexual abuse					
Victim of physical abuse					
Victim of sexual abuse					
Heart rhythm problems/arrhythmias					
Sudden death due to heart problem under age 50					
Congenital heart disease					

Please describe any **YES** answers above (e.g., what diagnoses or treatments were given):

_____

_____

_____

_____

_____

_____

_____

Siblings Family History

Please check whether any of your child's siblings has had the following problems:

Relationship to Child	Brother	Brother	Sister	Sister	
Problems with aggression, defiance, and oppositional behavior as a child					
Problems with attention, hyperactivity, and impulse control as a child					
Learning disabilities or poor school performance					
Failed to graduate from high school					
Mental retardation					
Autism or Pervasive Developmental Disorder					
Psychosis or schizophrenia					
Hospitalization in a psychiatric or mental hospital					
Depression greater than 2 weeks					
Anxiety disorder					
Obsessive Compulsive Disorder					
Bipolar or Manic-Depressive Disorder					
Tics or Tourette's Syndrome					
Alcohol abuse					
Substance abuse					
Antisocial behavior (assaults, thefts, etc.)					
Arrests or jail time					
Perpetrator of physical abuse					
Perpetrator of sexual abuse					
Victim of physical abuse					
Victim of sexual abuse					
Heart rhythm problems/arrhythmias					
Sudden death due to heart problem under age 50					
Congenital heart disease					

Please describe any **YES** answers above (e.g., what diagnoses or treatments were given):

_____

_____

_____

_____

_____

_____

Current Medications & Natural Remedies

Please list any medications (over the counter or prescribed) or herbal/natural remedies your child is ***currently*** taking: _____

_____

_____

_____

1. Many children with autism have difficulties with eye contact. Which of the following have been/are significant problems?

   Y/N Making eye contact with adults

   Y/N Making eye contact with peers

   Y/N Making eye contact during the first year of life

Please describe **yes** answers above:

_____

_____

_____

_____

_____

_____

2. Many children with autism have difficulties with social interaction. Which of the following are significant problems?

   Y/N Enjoying socializing with other children

   Y/N Seeking out other children to play

   Y/N Playing cooperatively with other children

Please describe **yes** answers above:

_____

_____

_____

_____

_____

3. Many children with autism have repetitive behaviors, like hand flapping, running in a specific circle, twirling, or spinning. Have you noticed repetitive behaviors in your child?

_____

_____

_____

4. Many children with autism have unusual preoccupations, such as a specific interest in a toy, TV show, book, or character. Have you noticed any usual preoccupations in your child?

_____

_____

_____

5. Many children with autism have unusual sensory sensitivities, such as to noises, lights, or textures of clothing or food. Have you noticed any sensory sensitivities in your child?

_____

_____

_____

6. Many children with autism have unusual sensory interests, such as smelling things, touching things, or watching spinning things. Have you noticed any usual sensory interests in your child?

_____

_____

_____

7. Many children with autism have a desire for structure or a need for specific routines. Have you noticed a desire for structure or a need for specific routines in your child?

_____

_____

_____

8. Has your child ever experienced or witnessed any emotional, physical, or sexual abuse or other trauma?

_____

_____

_____

Thank you! Please return these papers and other SMART Forms to your provider

SMART TOOL

Child's Name:_____ DOB:_____

Today's Date:_____ Location:_____

Name of person filling out form:_____

Relationship to child:_____

Social Communication & Interaction	True	False
Impairments in the use of eye contact during social interactions. *Example: Looks to the side or at your mouth rather than your eyes when speaking to you.*	☐	☐
Deficits in the use of facial expressions to communicate. *Example: Doesn't frown, pout, look surprised.*	☐	☐
Lack or reduced use of gestures to communicate. *Example: Doesn't wave bye bye, nod yes or no, blow a kiss*	☐	☐
Impairments in back and forth conversation (appropriate to language level) Example: Won't add something new or ask a question in response to a comment made to them.	☐	☐
Lack of, reduced, or impaired responses to social initiations of others. *Example: Doesn't respond to his/her name or acknowledge others.*	☐	☐
Lack of, or reduced interest in, peers (appropriate to developmental level)	☐	☐
Lack of, reduced, or impaired initiations of interactions with others	☐	☐
Reduced preference for some peers over others/impaired friendships	☐	☐
Delays in, or lack of, varied age-appropriate play with peers	☐	☐

Restricted, repetitive patterns of behavior, interests, & activities	True	False
Has atypical speech characteristics (e.g. echoing, jargon, unusual rhythm or volume)	☐	☐
Has repetitive body mannerisms	☐	☐
Reacts negatively to changes in schedule/insists on sameness	☐	☐
Has behavioral rituals	☐	☐
Has verbal rituals (e.g., must say things, or have others say things, in a particular way)	☐	☐
Has specific interests that are unusual in intensity (e.g., hobby of unusual intensity)	☐	☐
Engages in a limited range of activities/Has a limited behavioral repertoire	☐	☐
Shows hyper-reactivity to sensory input	☐	☐
Shows hypo-reactivity to sensory input	☐	☐
Shows unusual sensory interests and preferences	☐	☐

Disruptive Behavior	True	False
Engages in aggressive and/or destructive behaviors toward self, others, or objects (e.g. self-injury, elopement, property destruction)	☐	☐

Please include comments or other information to consider on this page. Make copies if needed.

_____

_____

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School Medical Autism Review Team (S.M.A.R.T.) Demographics Form

DATE OF REFERRAL: _____/_____/_____ PERSON REFERRING:_____

CHILD'S NAME:_____ DOB: _____/_____/_____

PARENT/GUARDIAN(S):_____

RELATIONSHIP TO CHILD:_____

MAILING ADDRESS:_____ CITY:_____ WA ZIP:_____

PRIMARY PHONE: (____)_____ ALTERNATE PHONE: (____)_____

INSURANCE:_____

SCHOOL/DAYCARE/BIRTH TO THREE:_____

_____

CURRENT TEACHER:_____

CURRENT LOCATION:_____

CURRENT OCCUPATIONAL THERAPIST:_____

CURRENT LOCATION:_____

CURRENT PHYSICAL THERAPIST:_____

CURRENT LOCATION:_____

CURRENT SPEECH LANGUAGE THERAPIST:_____

CURRENT LOCATION:_____

School Medical Autism Review Team (SMART)
Authorization for Release of Records

PURPOSE: As a parent/guardian, you have the right to give or not give permission for the release of your child's records to other persons or agencies. By signing this authorization, you are giving permission to exchange confidential information for Autism Spectrum Disorder screening purposes.

CHILD'S NAME:_____ **DOB:** _____

I hereby authorize the exchange of information orally, in writing, and/or electronically between the **School Medical Autism Review Team** (SMART) and the agencies/persons listed below:

Northwest Pediatric Center 1911 Cooks Hill Rd Centralia, WA 98531 Phone: (360) 736-6778 Fax: (360) 736-6552 ❑ CHECK HERE	(OR)	Valley View Health Center 2690 NE Kresky Avenue, Chehalis, WA 98532 Phone: (360) 330-9595 FAX: (360) 330-9530 ❑ CHECK HERE
Primary Care Provider (If other than Northwest Pediatric Center):		
Early Intervention Provider:		
Daycare:		
Therapist:		
School District:		
Other:		
Other:		

The records to be exchanged include: Medical/Health History information**,** Evaluation/Assessment results Developmental information, Educational Reports (Progress/IEP/504/IFSP)
Other:_____

This authorization is valid from _____/_____/_____to _____/_____/_____.

If not specified, this authorization is valid for one year from date signed.

I understand that the information obtained will be treated in a confidential manner and I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent release.

_____ _____
Parent/Guardian Signature Date

_____ _____
Patient Signature (if patient is 13 years of age or older) Date

SMART Packet Checklist

Child's name: _____ DOB: ___/___/___

Primary Care Provider: _____ Clinic: _____

School District: _____

FOR CHILDREN UNDER 3 YEARS OLD:

Included Forms:

- ☐ Authorization form release of records
- ☐ Demographics form
- ☐ Up to 3 SMART Tools – should be completed by family members and/or professionals (i.e., speech therapist, OT, daycare provider, psychologist, etc.) who best know the child

Additional Information:

- ☐ Enroll patient in Birth to 3 Program and include assessment results in SMART packet
  - Contact In-Tot Developmental Center at 1.360.736.4359
- ☐ **If at least 30 months old**, contact NWPC for SRS-2 forms for parent and teacher
- ☐ Reports of any testing done by school psychologists, occupational, language, or physical therapists, including any developmental screenings
- ☐ Reports of previous evaluations by physicians, psychologists, or psychiatrists

FOR CHILDREN AGES 3 YEARS AND OLDER:

Included Forms:

- ☐ Authorization form release of records
- ☐ Demographics form
- ☐ Up to 3 SMART Tools – should be completed by family members and/or professionals (i.e., speech therapist, OT, psychologist, special ed teacher etc.) who best know the child

Additional Information:

- ☐ Report cards (past 2 years)
- ☐ Request educational assessment from the school district you live in and include assessment in packet. For Lewis County contact Lewis County Special Education Co-op at 1.360.748.3384.
  - Allow 1-3 months for this process.
  - If assessment was denied, please include reason for denial.
- ☐ Contact NWPC for SRS-2 forms for parent and teachers
- ☐ Reports of any testing done by school psychologists, occupational, language, or physical therapists, including any developmental screenings
- ☐ Copies of 504 plans or IEPs
- ☐ Reports of previous evaluations by physicians, psychologists, or psychiatrists