care Developmental Questionnaire

Cindy Schneider, MD

Date: _____

Name of Patient:
First _____ Middle _____ Last_____

Date of Birth: _____ Place of Birth: _____ Age: _____ years _____ months

Gender: ○ Female ○ Male By what name would she/he like to be called? _____

Parents' Names: Mother: _____ Father: _____

Address:_____

_____
City State Zip Country

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Preferred daytime phone number: ○ Home ○ Work ○ Cell

Email Address: _____

Preferred method of communication: ○ Home Phone ○ Work Phone ○ Cell Phone ○ Email

Please send announcements, lecture schedules, and newsletters via: ○ Email ○ Regular mail ○ Neither

Ethnicity: ○ Caucasian ○ Hispanic/Latino ○ African American ○ Asian or Pacific Islander ○ Multiracial

○ Native American ○ Other: _____ ○ Unknown ○ Decline response

Emergency Contact: _____ Relationship: _____
First Name Last Name

Emergency Phone: (_____)_____ Alternate Phone: (_____)_____

Primary language spoken in your home: _____

Secondary language spoken in your home: _____

REFERRAL INFORMATION

How were you referred to care?

○ Friend ○ Physician ○ Colleague ○ Relative ○ Website ○ Other:_____

Referring person's name: _____

Child's primary care physician: _____

Physician's phone number: (_____)_____

Demographic Information

MOTHER'S NAME: _____

EDUCATION

○ High school ○ College, degree not completed ○ Bachelor's, Associate's, or professional degree

○ Master's degree ○ PhD ○ MD ○ DC ○ JD ○ DDS ○ Other: _____

EMPLOYMENT

Are you employed? ○ Yes ○ No Employer:_____

Occupation: _____ Job Title: _____

Typical number of hours worked per week: _____

If currently a full-time homemaker, please list previous occupation: _____

Ethnicity: ○ Caucasian ○ Hispanic/Latino ○ African American ○ Asian or Pacific Islander ○ Multiracial

○ Native American ○ Arab ○ Other: _____ ○ Unknown ○ Decline response

FATHER'S NAME: _____

EDUCATION

○ High school ○ College, degree not completed ○ Bachelor's, Associate's, or professional degree

○ Master's degree ○ PhD ○ MD ○ DC ○ JD ○ DDS ○ Other: _____

EMPLOYMENT

Are you employed? ○ Yes ○ No Employer:_____

Occupation: _____ Job Title: _____

Typical number of hours worked per week: _____

If currently a full-time homemaker, please list previous occupation: _____

Ethnicity: ○ Caucasian ○ Hispanic/Latino ○ African American ○ Asian or Pacific Islander ○ Multiracial

○ Native American ○ Arab ○ Other: _____ ○ Unknown ○ Decline response

Marital status of parents: □ Married □ Never married □ Separated □ Divorced □ Widowed

Family income: ☐ $50,000 or less ☐ $51,000 or above

CHILD'S SCHOOL PLACEMENT

Name of school: _____

Please describe your child's school placement:

☐ Mainstreamed with an aide ☐ Mainstreamed without an aide ☐ Self-contained special education
☐ Home schooled ☐ Day care ☐ Reverse mainstream special education
☐ Typical preschool ☐ Resource classes as needed ☐ Not yet in school

Prenatal History

Indicate any of the following complications that occurred during your pregnancy **with this child.**

○ Took longer than 6 months to conceive
☐ Pregnancy achieved through infertility drugs and/or artificial insemination. Describe: _____
☐ Abnormal maternal serum alpha fetal protein (MSAFP) blood test in second trimester
☐ Alcohol use
☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester
☐ 1 drink per day or less ☐ greater than 1 drink per day
☐ Amniocentesis at ____ weeks
☐ Asthma
☐ Beta Strep vaginal colonization (typically asymptomatic in mother, but treated during labor)
☐ Bleeding
☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester
☐ Chemical or toxic exposure
☐ anesthetic gases/anesthesia
☐ dental amalgams placed or repaired during pregnancy
☐ indoor pesticides
☐ lead
☐ new carpeting
☐ new paint
☐ outdoor pesticides
☐ other: _____
☐ Cigarette smoking
☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester
☐ ½ pack per day or less ☐ greater than ½ pack per day
☐ Diabetes
☐ Gestational diabetes
☐ High blood pressure
☐ Chronic hypertension
☐ Pregnancy-induced hypertension
☐ Hypothyroidism (underactive thyroid)
☐ Infection or illness
☐ Mononucleosis (Epstein-Barr virus)
☐ Bladder infection
☐ Pyelonephritis (kidney infection)
☐ Other: _____
☐ Placenta previa (low placenta)
☐ Preterm/premature labor (requiring bed rest or medical care) beginning at ___ weeks
☐ Protein in urine
☐ Radiation exposure
☐ Severe nausea and/or vomiting (hyperemesis)
☐ Substance use:
☐ marijuana ☐ heroine ☐ hallucinogens
☐ cocaine ☐ narcotics ☐ amphetamines
☐ other: _____
☐ Toxemia/preeclampsia beginning at ____ weeks gestation
☐ Twin pregnancy ☐ Triplet pregnancy ☐ Other: _____
☐ Prescription medication use: _____ ☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester
☐ Injury: _____
☐ Vaccination within 3 months prior to conception or during pregnancy
(Please specify): ○ Flu shot ○ DTaP ○ Other: _____ When given: _____
☐ Vegetarian diet
☐ Other: _____
☐ No complications occurred during pregnancy

Perinatal and Neonatal History

Mother's age at birth: ____ years Father's age at time of birth: ____ years
Weight gained during pregnancy: ____ pounds

Number of silver/mercury fillings present during pregnancy: ____
Number of servings of tuna, swordfish, or other high mercury fish per month: ____

Was labor induced with Pitocin?
☐ No ☐ Yes ☐ Uncertain
Was labor induced with prostaglandin gel?
☐ No ☐ Yes ☐ Uncertain
Was labor augmented with Pitocin?
☐ No ☐ Yes ☐ Uncertain

This child was born by:
☐ Normal vaginal delivery
☐ Forceps vaginal delivery
☐ Vacuum extraction
☐ Breech vaginal delivery
☐ Cesarean delivery due to:
- ☐ large baby/failure to progress in labor
- ☐ fetal distress (low or worrisome heartbeat)
- ☐ breech or other abnormal presentation
- ☐ placenta previa (low placenta)
- ☐ scheduled repeat cesarean
- ☐ other: _____

Length of pregnancy:
☐ Premature
☐ Full term
☐ Past due date (>40 weeks)
☐ < 1 week late ☐ 1-2 weeks late ☐ > 2 weeks late
Born at _____ weeks
Birth weight: ___ pounds ___ ounces
Apgar scores: _____ (1 minute) _____ (5 minutes) _____ Unknown

Discharged from the hospital when ___ day(s) / ___ week(s) old

Did your child receive the hepatitis B vaccine within the first week of life?
☐ Yes ☐ No ☐ Uncertain
How may flu vaccines has your child received and at what age(s)? _____

Check any complications that occurred at birth or during your child's first month of life:
☐ Abnormal result on newborn screening test: _____
☐ Anemia
☐ Birth defect (please describe): _____
☐ Birth injury (e.g. fractured collarbone); please specify: _____
☐ Breathing difficulty/required oxygen for more than 20 minutes
☐ Cord around neck
☐ Difficulty nursing or drinking from a bottle
☐ Difficulty regulating temperature
☐ Frequent or projectile vomiting
☐ Heart murmur or irregular heart rhythm
☐ Meconium-stained amniotic fluid ☐ with aspiration into lungs ☐ without aspiration
☐ Illness: _____
☐ Jaundice: ☐ required phototherapy (bilirubin lights) ☐ did not require phototherapy
☐ Seizures: _____
☐ Unable to tolerate milk-based formula
☐ Yeast infection (thrush, cradle cap, etc.)
☐ Other: _____

Diagnostic Information

Child's diagnosis:

- ☐ Non-applicable (no diagnosis)
- ☐ Attention deficit disorder (ADD or ADHD)
- ☐ Autism
- ☐ Asperger's syndrome
- ☐ Pervasive developmental disorder not otherwise specified (PDD, PDD-NOS)
- ☐ Atypical autism
- ☐ Sensory processing disorder
- ☐ PANDAS, PITANDS, or PANS
- ☐ Landau-Kleffner syndrome
- ☐ Tic disorder or Tourette's
- ☐ Other: _________

Additional diagnoses:

- ☐ None
- ☐ Bipolar disorder (manic depressive disorder)
- ☐ Blindness/visual impairment
- ☐ Cerebral palsy
- ☐ Chromosomal abnormality: _____
- ☐ Down syndrome
- ☐ Dyslexia
- ☐ Fragile X
- ☐ Hearing loss
- ☐ Hyperlexia (advanced reading skills)
- ☐ Learning disability
- ☐ Mental retardation
- ☐ Mitochondrial disorder
- ☐ Obsessive compulsive disorder (OCD)
- ☐ Seizure disorder
- ☐ Speech/language delay
- ☐ Other: _____

If your child does not have developmental delays or neurological symptoms, please proceed to the next page.

In my opinion, my child's disability is:_____ Mild _____ Moderate _____ Severe

Do you think that your child was born with a neurological impairment?

- ☐ Yes, my child was very different from birth
- ☐ No, my child seemed to develop and interact in a typical way until a certain age

At what age did you suspect your child had a disability? _____ months
Age at diagnosis: _____ months

Who made the diagnosis? (Check all that apply)

- ☐ Developmental pediatrician
- ☐ Neurologist
- ☐ Pediatrician
- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Other:_____

Please check any therapies your child has received in the past or is currently receiving:

Type of therapy	Currently	In the Past	Start Date
Applied Behavioral Analysis (ABA, Lovaas, etc.)	_____	_____	_____
Auditory Training (Berard, Tomatis, etc.)	_____	_____	_____
Craniosacral therapy	_____	_____	_____
Chiropractic care	_____	_____	_____
Feeding therapy	_____	_____	_____
Hyperbaric oxygen therapy	_____	_____	_____
Music therapy	_____	_____	_____
Special education classes	_____	_____	_____
Regular education classes	_____	_____	_____
Occupational therapy/sensory integration	_____	_____	_____
Physical therapy	_____	_____	_____
Relationship Development Intervention (RDI)	_____	_____	_____
Speech therapy	_____	_____	_____
Therapeutic horseback riding	_____	_____	_____
Other: _____	_____	_____	_____

Number of children in family: _____

Child's birth order:

☐ 1st ☐ 3rd ☐ 5th or higher
☐ 2nd ☐ 4th ☐ Adopted

Other children in the family:

Name	Date of birth	Sex(M/F)	Developmental Delays?	Place of Residence

Number of miscarriages prior to pregnancy with affected child:

☐ None
☐ One
☐ Two
☐ Three or more

Was Rhogam given during pregnancy? (Injection routinely given to Rh negative women)

☐ Yes
☐ No
☐ Uncertain

Developmental and Health History

Check any medical illnesses that your child has currently or has had in the past:

☐ Adverse reaction to a vaccination: _____
☐ Asthma
☐ Chronic constipation beginning at ____ months of age to age _____.
☐ Chronic diarrhea beginning at ____ months of age to age _____.
☐ Encephalitis or meningitis at ____ months
☐ Eczema
☐ Febrile seizures (fever-related) at ____ months
☐ Grand mal seizures (tonic clonic) Onset at age ____ months
☐ Petit mal seizures (complex partial or simple) Onset at age ____ months
☐ Strep throat or other Strep infection
☐ Thrush
☐ Other medical illness: _____

Is your child allergic to any medication? ☐ No ☐ Yes: _____

Number of otitis media (inner ear) infections in the**:**

First year of life	**Second year of life**	**Third year of life**
☐ 0-3	☐ 0-3	☐ 0-3
☐ 4-6	☐ 4-6	☐ 4-6
☐ 7 or more	☐ 7 or more	☐ 7 or more

At what age did your child achieve the following developmental milestones?

Coo	_____ months	
Babble (“mamma”, “baba”, etc)	_____ months	
Speak his or her first **true** word	_____ months	☐ My child has never spoken.
Speak in two-word phrases	_____ months	☐ Not yet using 2-word phrases
Speak in sentences	_____ months	☐ Not yet speaking in sentences

Did your child ever lose language (babbling, words, and/or receptive language)?

☐ No
☐ Yes, at: ☐ <15 months ☐ 15-18 months
☐ 19-24 months ☐ 25-30 months
☐ 31-36 months ☐ 37 months or older

Which best describes your child:

☐ Accelerated language development
☐ Normal language development
☐ Normal language development until approximately _____ months, followed by a plateau
☐ Normal language development until approximately _____ months, followed by a regression
☐ Always slow to acquire language with no obvious period of regression
☐ Always slow to acquire language and then regression in language at _____ months of age

Did your child ever lose the ability to use gestures, such as pointing or waving goodbye?

☐ No
☐ Yes, at: ☐ <15 months
☐ 15-18 months
☐ 19-24 months
☐ 25-30 months
☐ 31-36 months
☐ 37 months or older

At what age did your child learn to do the following:

Roll over (front to back) _____ months
Sit without support _____ months
Crawl on hands and knees _____ months
Walk _____ months

Did your child ever lose gross motor skills such as walking, running, jumping, or climbing?

□ No
□ Yes, at:
- □ <15 months
- □ 15-18 months
- □ 19-24 months
- □ 25-30 months
- □ 31-36 months
- □ 37 months or older

Did your child ever lose fine motor skills such as drawing or doing finger movements to children's songs?

□ No □ Yes, at:
- □ <15 months
- □ 15-18 months
- □ 19-24 months
- □ 25-30 months
- □ 31-36 months
- □ 37 months or older

Did your child ever experience a regression in social skills (e.g. eye contact, ability or desire to play with peers, response to parents' attempts at interaction)?

□ No
□ Yes, at:
- □ <15 months
- □ 15-18 months
- □ 19-24 months
- □ 25-30 months
- □ 31-36 months
- □ 37 months or older

Which best describes your child?

□ My child is not and has never been toilet trained.
□ My child is currently toilet trained, but was not toilet trained until age 3½ or later.
□ My child was toilet trained at one time, but regressed and now has frequent stool and/or urine accidents.
□ My child was toilet trained by 3½ years of age and never or rarely has accidents.

List any hospitalizations, surgeries, or serious injuries that your child has had:

□ None
Hospitalized for _____ Date: _____
Surgery: _____ Date: _____
Injury: _____ Date: _____

Has your child's hearing been tested? ○ No ○ Yes, at _____on ___/___/___
Has your child's vision been tested? □ No □ Yes, at _____on ___/___/___
Do you have concerns regarding your child's vision or hearing? □ No □ Yes: _____

Nutritional Information

My child was breastfed for:

☐ Breastfed for ____ months ☐ Not breastfed

My child was bottle fed with:

☐ Non-applicable (exclusively breastfed)
☐ Milk-based formula (Enfamil, Similac, etc.) from ____ to ____ months
☐ Soy-based formula (Isomil, Prosobee, etc.) from ____ to ____ months
☐ Other: _____ from ____ to ____ months

Did your child have colic as a newborn?

☐ No ☐ Yes, from ____ to ____ months of age

Dairy products (milk, cheese, yogurt, etc.) were introduced into my child's diet at:

☐ Never introduced
☐ 0-6 months
☐ 7-12 months
☐ 13 months or older

My child became a picky eater at:

☐ Non-applicable
☐ 12 months or younger
☐ 13-15 months
☐ 16-18 months
☐ 19-24 months
☐ 25-36 months
☐ 37 months or older

Check any food allergies or sensitivities that are known:

○ Citrus fruits
○ Corn
○ Dairy/casein
○ Eggs
☐ Other: _____
○ Gluten/wheat
○ Peanuts
○ Soy
○ Yeast
☐ No known food allergies

Is your child on a special diet? (check all that apply and indicate date diet was initiated)

☐ No dietary restrictions
☐ Casein/dairy free
☐ Corn free
☐ Feingold diet (salicylate free)
☐ Food dye free
☐ GAPS diet
☐ Gluten free
☐ Ketogenic diet
☐ Paleo diet
☐ Soy free
☐ Specific carbohydrate diet
☐ Vegetarian
☐ Yeast free
☐ Other: _____

What percent of your child's diet is organic? ☐ 0-10% ☐ 11-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

My child regularly eats the following (check all that apply):

☐ Beans
☐ Beef
☐ Dairy products
☐ Eggs
☐ Fish
☐ Fresh fruits
☐ Fresh vegetables
☐ Gluten-free foods (bread, cereal, etc.)
☐ Grains containing gluten
☐ Peanuts or peanut butter
☐ Potatoes
☐ Poultry (chicken, turkey, etc.)
☐ Pork
☐ Rice or rice products
☐ Seeds (pumpkin, sunflower, etc)
☐ Sweets/desserts
☐ Tree nuts
☐ Other: _____

How many **ounces** of the following beverages does your child drink daily?

____ Almond milk ____ Cow's milk ____ Juice ___ Water ___ Sports drinks
____ Fruit punch ____ Rice milk ____ Soy milk ___ Soda ___ Other:_____

Gastrointestinal Questionnaire

My child typically has ____ stool(s) per □ day / □ week of
□ normal □ watery □ soft or pasty □ loose □ hard consistency.

Please check any gastrointestinal symptoms your child has or has had for one month or more.

Symptom	Currently	In the Past
Bloating or gas	_____	_____
Diarrhea (loose or watery stools)	_____	_____
Constipation (hard and/or infrequent stools)	_____	_____
Large volume stools	_____	_____
Abdominal pain	_____	_____
Vomiting, reflux, and/or spitting-up	_____	_____
Blood in the stool	_____	_____
Selective appetite/picky eater	_____	_____
Excessive thirst	_____	_____
Foul smelling stools	_____	_____

Please answer the following questions if your child has any **current symptoms*:***

Diarrhea:
How often does your child have diarrhea in an average day?
□ Less than 3 times a day
□ 3-4 times a day
□ Greater than 4 times a day

If your child currently has diarrhea, what is the consistency?
□ Soft
□ Loose/mushy
□ Watery

Constipation:
How many bowel movements does your child typically have per week?
□Greater than 2 per week
□ 2 per week
□ Less than 2 per week

If your child currently has constipation, what is the consistency?
□ Formed
□ Hard/pebbles
□ Hard with pain or large volume stools

Abdominal Pain:
How often does your child exhibit signs of abdominal pain?
□ Never or rarely
□ 1-2 times per week
□ Greater than two times per week

Vomiting/reflux:
How often does your child show evidence of this?
□ Never or rarely
□ 1-2 times per week
□ Greater than two times per week

Medication History

Check any medications or vitamins your child has taken within the past month or at any time in the past.

		Currently	In the past	Dosage
Antifungal agents:	Diflucan			
	Nizoral			
	Nystatin			
Chelating Agents	EDTA			
	DMSA			
	DMPS			
Psychotropics:	Adderall			
	Concerta			
	Ritalin			
	Buspar			
	Clonidine (Catapres)			
	Effexor			
	Geodon			
	Namenda			
	Paxil			
	Prozac			
	Strattera			
	Risperdal (risperidone)			
	Tenex			
	Wellbutrin (bupropion)			
	Zoloft			
	Zyprexa			
Anti-seizure:	Depakote			
	Tegretol			
	Other: _____			
Steroids:	Dexamethasone			
	Prednisone			
Vitamins:	Aperture			
	B6 or P5P			
	Leucovorin			
	Methyltetrahydrofolate (5-MTHF)			
	Methylcobalamin (B12) injections			
	Other multivitamin (please specify)			
	Vitamin D3			
Supplements:	Calcium			
	Cod liver oil			
	DHA (docasahexanoic acid)			
	DMG (dimethylglycine)			
	EPA			
	Evening Primrose Oil			
	Magnesium			
	Selenium			
	TMG (trimethylglycine)			
	Zinc			
	Digestive enzymes			
GI medications:	Prilosec			
	Miralax			
	Pentasa			
	Pepcid			
	N-acetyl glucosamine			
	Probiotics			
	Zantac			
	Other: _____			

FAMILY MEDICAL HISTORY

Please indicate if your child or anyone in your immediate family has had any of the following conditions. List family members as related to your child (e.g., his or her mother's grandfather). Use "D" if deceased due to this condition. Include extended family or other conditions if relevant.

Medical Condition	Relationship to Patient												
						Mother's Side				Father's Side			
	Child	Mother	Father	Bro	Sis	Aunt	Uncle	GF	GM	Aunt	Uncle	GF	GM
Alcoholism													
Anxiety Disorder/Panic Attacks													
Asthma													
Autism / PDD NOS													
Asperger's Syndrome													
ADD / ADHD													
Alzheimer's													
Anorexia / Bulimia													
Bipolar Disorder													
Depression													
Down Syndrome													
Dyslexia													
Eczema													
Elevated Cholesterol													
Epilepsy / Seizures													
Gout													
Language Delay													
Heart Disease													
Hypertension / High Blood Pressure													
Kidney Stones													
Mental Retardation													
Migraines													
Night Blindness													
Obsessive Compulsive Disorder													
Parkinson's Disease													
Rett's Disorder													
Schizophrenia													
Spina Bifida or other NTD													
Stuttering													
Stroke													
Suicide or attempted suicide													
Tourette's Syndrome													
Tremor													
Vertigo / Meniere's Disease													
Gastrointestinal:													
Celiac Disease													
Crohn's Disease													
Eosinophilic Esophagitis													
Irritable Bowel Syndrome													
Pancreatitis													
Peptic Ulcer Disease													
Reflux Esophagitis / GERD													
Ulcerative Colitis													
Autoimmune:													
Ankylosing Spondylitis													
Chronic Fatigue Syndrome													
Diabetes													
Fibromyalgia													
Lupus (SLE or discoid)													
Multiple Sclerosis													
Psoriatic Arthritis													
Rheumatoid Arthritis													
Thyroid Disease													
Vitiligo													
Other:													

CANCER

If anyone in your child's family has had cancer, please specify:

☐ Brain: _____ ☐ Breast: _____ ☐ Cervical: _____ ☐ Colon/rectum: _____
☐ Kidney: _____ ☐ Leukemia: _____ ☐ Lung: _____ ☐ Lymphoma: _____

☐ Oral (mouth, tongue): _____ ☐ Ovarian: _____ ☐ Pancreatic: _____

☐ Prostate: _____ ☐ Skin: _____ ☐ Stomach: _____ ☐ Uterine: _____

Other: _____

Which of the following are health priorities in your child's care at this time?

- ☐ Decrease pain level
- ☐ Enhance cognitive function
- ☐ Improve attention span
- ☐ Increase energy level / reduce fatigue
- ☐ Improve sleep pattern
- ☐ Improve nutritional status
- ☐ Increase language
- ☐ Improve coordination
- ☐ Increase endurance
- ☐ Increase range of motion/flexibility
- ☐ Increase muscle mass
- ☐ Decrease allergy symptoms Improve diet
- ☐ Decrease self-stimulatory behaviors
- ☐ Initiate detoxification program
- ☐ Decrease self-injurious behaviors
- ☐ Optimize health prior to surgery
- ☐
- ☐ Improve balance
- ☐ Improve concentration
- ☐ Minimize need for medication
- ☐ Balance/optimize hormone levels
- ☐ Improve memory
- ☐ Reduce frequency of headaches
- ☐ Reduce risk of cardiovascular disease
- ☐ Reduce risk of diabetes
- ☐ Minimize tantrums or mood swings
- ☐ Overcome depression
- ☐ Decrease anxiety level
- ☐ Decrease obsessive-compulsive tendencies
- ☐ Decrease sensory sensitivities
- ☐ Improve or develop exercise program
- ☐ Increase social interaction
- ☐ Increase eye contact
- ☐ Other: _____

What are your primary concerns?

If your child's health history is complicated, please provide a 1-3 page written summary of his or her challenges, assessments, interventions, and therapeutic response to date. Please include any response to past treatments, whether positive or negative and indicate which interventions you have found to be most helpful.

Developmental and Behavioral Survey

Cindy Schneider, MD

For each set of descriptions, circle the number which best describes your child **DURING THE PAST MONTH**.

1	2	3	4	5
Never	**Rarely**	**Occasionally**	**Frequently**	**Always**

Communication:

1.	Able to communicate needs verbally	1 - Never
2.	Able to communicate needs nonverbally (through gestures, sign language, etc.)	1 - Never
3.	Responds when name is called (turns head, looks at parent)	1 - Never
4.	Asks questions	1 - Never
5.	Answers questions	1 - Never
6.	Repeats words or phrases (immediate or delayed echolalia)	1 - Never
7.	Able to understand simple directions (“come here”, “close the door”, etc.)	1 - Never
8.	Makes spontaneous comments	1 - Never

Social Interaction:

9.	Shows concern when seeing someone sad or hurt (demonstrates empathy)	1 - Never
10.	Looks at parent to share expressions of pleasure during enjoyable activity	1 - Never
11.	Maintains age-appropriate eye contact	1 - Never
12.	Smiles in response to another person (social smile)	1 - Never
13.	Responds (verbally or nonverbally) to another child’s request to play	1 - Never
15.	Initiates a request to play with peers (verbally or nonverbally)	1 - Never
16.	References parent to obtain feedback on behavior	1 - Never
17.	Enjoys new people and places	1 - Never
18.	Affectionate and loving toward parents	1 - Never
19.	Enjoys being held or hugged by parents	1 - Never

Behavior:

20.	Laughs or giggles without obvious reason	1 - Never
21.	Exhibits repetitive or self-stimulatory behavior	1 - Never
22.	Flaps arms or hands	1 - Never
23.	Unusual toy play (e.g. lining up, stacking, or spinning toys)	1 - Never
24.	Disturbed by changes in routine	1 - Never
25.	Eats inedible objects (e.g. dirt, sand, wood, paper, etc.)	1 - Never
26.	Destructive	1 - Never
28.	Aggressive (bites, hits, or otherwise harms others)	1 - Never
29.	Bites his/her hand, wrist, or arm	1 - Never
30.	Bangs or hits his/her head	1 - Never
31.	Hyperactive	1 - Never
32.	Has difficulty completing activities (short attention span)	1 - Never
33.	Has difficulty transitioning from one place or activity to another	1 - Never

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Sensory Issues:

34.	Bothered by certain lighting conditions (fluorescent lights, sunlight, camera flash)	1 - Never
35.	Examines objects or fingers closely in front of eyes	1 - Never
36.	Enjoys vestibular activities such as swinging and spinning	1 - Never
37.	Places hands over ears and/or unusually fearful of certain noises	1 - Never
38.	Grinds teeth	1 - Never
39.	Has a high pain threshold	1 - Never
40.	Avoids certain textures (e.g., finger paints, sticky substances)	1 - Never
41.	Disturbed by certain items of clothing or textures of fabric	1 - Never
42.	Refuses foods based on texture (too chunky, too smooth, etc.)	1 - Never

Daily Living Skills:

43.	Able to put on shirt without assistance	1 - Never
44.	Able to put on pants without assistance	1 - Never
45.	Combs hair	1 - Never
46.	Aware of approaching danger such as cars, swings, etc.	1 - Never
47.	Washes hands with age-appropriate skill	1 - Never
48.	Brushes teeth with age-appropriate skill	1 - Never
49.	Uses a spoon or fork to eat	1 - Never
50.	Urinates in the toilet	1 - Never
51.	Has bowel movements in the toilet	1 - Never

Sleep:

52.	Has difficulty falling asleep	1 - Never
53.	Awakens in the middle of the night	1 - Never
54.	Wets diaper or bed at night	1 - Never
55.	Does not sleep well unless in parents' bed	1 - Never

Motor Skills:

56.	Walks with a normal gait	1 - Never
57.	Runs with a normal gait	1 - Never
58.	Able to jump up and down	1 - Never
59.	Able to climb up stairs one step at a time	1 - Never
60.	Climbs on chair to reach a desired object	1 - Never
61.	Able to catch a large ball	1 - Never
62.	Able to kick a ball	1 - Never
63.	Copies a straight line	1 - Never
64.	Able to write name	1 - Never
65.	Rides a tricycle or bicycle with training wheels	1 - Never
66.	Has a good sense of balance	1 - Never