STONY BROOK UNIVERSITY HOSPITAL
NEUROPSYCHOLOGY SERVICE
PARENT QUESTIONNAIRE

Today's Date (Mo/Day/Yr) ______/______/______

Child's Name (First/Last) ____

Birth Date (Mo/Day/Yr): _____/_____/_____ Age: ___________ Gender: _______ Female _______ Male (1)

Your Name (First/Last): ____ Your relationship to the child: __________________

Who referred you to us? ____

Has your child previously been seen at Stony Brook University Hospital? ______ No (1) ______ Yes (2)

If yes, approximately when was your child seen? ____

Who saw your child at that time? (If you don't recall who, which Department) ____

OTHER CARE PROVIDERS:

Primary Physician Name: ____ Telephone #: (   ) ________________________

Psychiatrist Name: ____ Telephone #: (   ) ________________________

Psychotherapist Name: ____ Telephone #: (   ) ________________________

Other Care Providers (neurologist, speech therapist, etc.):

Name: ____ Telephone #: (   ) ________________________

Name: ____ Telephone #: (   ) ________________________

Name: ____ Telephone #: (   ) ________________________

CHILD'S HOME ADDRESS AND TELEPHONE (Please include Zip code)

____
Address

____
City, State, Zip code

____
Home Telephone

____
Cell Phone

Please read the following questions carefully and answer each one as thoroughly as possible. NOT all questions will apply to your child. When this is the case, please indicate so by writing N/A by the question.

CURRENT CONCERNS:

What are the main problems you are concerned about, and how long have they been present?

Problem	Present since (age)

EARLY DEVELOPMENTAL HISTORY: *(If you don't know, please write DK)*

1. How many pregnancies did mother have before the birth of this child? (include those not carried to term) ________
2. Check **ANY** of the following that occurred during the pregnancy with this child:

__________ No complication

__________ Severe Nausea and Vomiting __________ Toxemia __________Heart Disease

__________ High Blood Pressure __________ Rubella, Mumps __________Injury/Accident

__________ Incompatible Rh Factor __________ Gestational Diabetes __________Hospitalization

__________ Kidney Disease __________ Anemia __________Seizures

__________ Bleeding: _____ 1st 3 mos. _____ 2nd 3 mos. _____ 3rd 3 mos.

3. Were any medications taken during pregnancy? __________ NO (1) __________ (YES (2)

If YES, please specify: ____

____

4. Did the mother smoke or take drugs during the pregnancy? _________ (NO (1) __________ (YES) (2)

If YES, specify what, how much, and when: ____

____

5. Did the mother consume alcohol during the pregnancy? __________(NO (1) __________ (YES (2)

If YES, specify how much and when: ______ ____

____

6. Delivery Information:

Type of delivery (Check one): _____ Normal _____ C-Section _____ Breech _____ (Forceps

Was labor induced? __________ NO (1) __________ YES (2)

Did ANY of the following occur at or following the delivery of the child:

__________ No problems with delivery, or following delivery

__________ Premature delivery: How many days before due date? __________

__________ Late delivery: How many days past due date? __________

__________ Infant had cord around neck

__________ Infant was blue at birth

__________ Infant was jaundiced: How treated? __________

__________ Infant required oxygen: For how long? __________

__________ Infant required blood transfusion: For what reason?__________

__________ Infant was placed in an incubator: For how long? __________

__________ Other problems (please specify): ____)

7. Child's weight at birth: __________ pounds __________ ounces

APGAR Scores: __________ 1 minute __________ 5 minutes

Length of hospital stay: _________ Was this longer than the Mother's stay? _________ NO (1) __________ YES (2)

If YES, provide the reason. ____

____

8. As an infant, how would you have described your child? (Check **ALL** that apply)

__________ Slept too much __________ Unresponsive to parents/familiar adults

__________ Rarely seemed to sleep __________ Seemed "too good"

__________ Fussed excessively __________ Colicky

__________ Feeding difficulties __________ Overly active

__________ Resisted being held __________ Excessively clingy

__________ No reaction to separation __________ No or unusual reaction to strangers

DEVELOPMENTAL MILESTONES *(if you don't know, please write DK)*

Please provide the age at which your child accomplished the following milestones:

Milestone	Age in months or years	Milestone	Age in months or years
Rolled over		Ate with utensils	
Sat unsupported		Cut with scissors	
Crawled		Toilet trained during day (bladder)	
Walked independently		Toilet trained at night (bladder)	
Rode a tricycle		Toilet trained during day (bowel)	
Rode a bicycle		Toilet trained at night (bowel)	
Gestures(bye-bye,etc)			
Babbling			
Spoke single words			
Spoke in phrases (2-3 words)			
Spoke in sentences (4+ words			

Has your child established handedness yet? _____ NO (1) _____ YES (2) If YES, which hand _____ Right (1) _____ Left (2)

Prior to the development of speech, did your child? (**PLEASE CHECK ALL THAT APPLY**)

_____ use physical gestures to gain parent's attention
_____ point to desired objects
_____ pull parents to desired objects
_____ use parent's hands as a tool, such as placing parent's hand on door to indicate the child wanted to leave?
_____ wave bye-bye or hello without prompting
_____ try to share interests with others (such as offering parents food or interesting toys)

MEDICAL HISTORY

1. Please check **ALL** that apply to the child:

_____ Birth Abnormalities
_____ Heart Disease
_____ Anemia
_____ Physical handicaps
(describe:_____________________________________)
_____ Asthma
_____ Allergies
(describe:_____________________________________)
_____ Food sensitivities
_____ Lead poisoning
_____ Other poisoning
(describe:_____________________________________)
_____ Chicken Pox
_____ Problems with vision
_____ Problems with hearing

_____ Epilepsy/seizures/convulsions
_____ Seizures with high temperature
_____ Fever over 104 with unknown cause
_____ Emergency Room visit
(describe: _______________________________)
_____ Head Injury
_____ Head Injury with loss of consciousness
_____ Loss of consciousness other than above
_____ Serious accident
_____ Meningitis
_____ Recurrent ear infections
_____ Encephalitis
_____ Mumps
_____ Other serious childhood disease
(describe: _______________________________)

2. Is your child taking medication for any of the above medical ailments? _____ NO (1) _____ YES (2)
If YES, describe: ____
____

3. Has your child ever been hospitalized for a medical problem? _____ NO (1) _____ YES (2)
   If YES, reason: ____
   When? ______________________ Where? ______________________

4. Has your child ever been hospitalized for a behavioral or psychiatric problem? _____ NO (1) _____ YES (2)
   If YES, reason: ____
   When? ______________________ Where? ______________________

PRIOR TESTS

Has your child received a medical work-up. Such as:

EEG's _____ NO (1) _____ YES (2)

If YES, please provide reason/results: ______________________

Fragile X _____ NO (1) _____ YES (2)

If YES, please provide reason/results: ______________________

MRI _____ NO (1) _____ YES (2)

If YES, please provide reason/results: ______________________

OTHER TESTS (hearing, metabolic, endocrine, etc.):

__________ please provide reason/results: ______________________

__________ please provide reason/results: ______________________

IMMUNIZATIONS

Are your child's immunizations appropriate for his age? _____ NO (1) _____ (YES (2)

If not, please mention which are not current:

____

____

ALLERGIES

Please list any medication allergies your child has:

Name of medication ______________ Allergic Reaction ______________

Name of medication ______________ Allergic Reaction ______________

Name of medication ______________ Allergic Reaction ______________

Other allergies:

____

____

PREVIOUS EVALUATIONS

1. Has your child ever received a diagnostic evaluation before? _____ NO (1) _____ YES (2)
   Is YES, please specify (if more than one evaluation, please put additional information at bottom of page):
   Where and when was child seen? ______________________
   By whom? ______________________
   What diagnosis was given? ______________________
   If possible, please enclose a copy of the report(s) with this questionnaire.
   Additional comments: ______________________
   ____
   ____
   ____

MEDICATION HISTORY

1. Has your child every been treated with medication for his/her problems? _____ NO (1) _____ YES (2)

   If YES, list each medication, dosage, and age of child:

   Name/dose of Medication: ____ (age _____ to _____)

   Name/dose of Medication: ____ (age _____ to _____)

   Name/dose of Medication: ____ (age _____ to _____)

   Name/dose of Medication: ____ (age _____ to _____)

   Name/dose of Medication: ____ (age _____ to _____)

   Name/dose of Medication: ____ (age _____ to _____)

2. Is your child taking medication at the present time? _____ NO (1) _____YES (2)

   Name/dose of Medication: ____ (age _____ to _____)

   Name/dose of Medication: ____ (age _____ to _____)

   Name/dose of Medication: ____ (age _____ to _____)

   Name/dose of Medication: ____ (age _____ to _____)

   Name/dose of Medication: ____ (age _____ to _____)

   Name/dose of Medication: ____ (age _____ to _____)

SCHOOL INFORMATION

CURRENT EDUCATIONAL PLACEMENT:

3. What school district do you live in? ____

4. What school does your child currently attend? ____

   Address:

   ____

   ____

   Telephone #: (   ) ___________________________ Teacher: ________________________________

5. Current grade (if summer, give grade starting in September): __________

6. Has your child been evaluated by the CSE or CPSE: __________ NO (1) __________ YES (2)

7. Does your child have a Special Education Classification? (e.g., Autism, Speech/Language Impaired, OHI)

   __________ NO (1) __________ YES (2) (If YES, please specify: _____________________________)

6. Is your child currently receiving Special Education Services?__________ NO (1) __________ YES (2)

7. What sort of classroom does your child attend?

   __________ Regular Education (0)

   __________ Inclusion Classroom (1)

   __________ Regular Education with Resource Room (what subjects?) (2) ________________________________

   __________ Special Education Classroom in Home District (3)

   What is the student/teacher ratio? (e.g., 12:1:1) _________________________

   Is your child mainstreamed for any subjects? ____

   __________ Special Education Classroom in Special Education School (includes Preschool Programs (4)

   What is the student/teacher ratio? (e.g., 12:1:1) _________________________

   __________ Residential or Hospital Setting (5)

8. What supportive services does your child receive (e.g., speech therapy, OT, PT, counseling)?

   a) __________________________________ How many times per week? __________

   b) __________________________________ How many times per week? __________

   c) __________________________________ How many times per week? __________

9. What, if any, are your current concerns regarding your child's educational programming?

____

____

____

____

____

____

D. EDUCATIONAL HISTORY

For each grade in school, please check all of the following that apply. If your child does not yet attend school, please skip this section and go to the next.

School Year	Type of School (✓ one)		Type of Class (✓ one)		Special Services (Please check all that apply)		
	Regular	Special	Regular	Special	Service	Type	Session Length/ Frequency
Early Intervention services ages (birth – 3 years) Name of school:	NOT APPLICABLE				□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
Pre-School Services Ages (3 yrs – 5 yrs) Name of school:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
Kindergarten Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
1st Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK

School Year	Type of School (✓ one)		Type of Class (✓ one)		Special Services (Please check all that apply)		
	Regular	Special	Regular	Special	Service	Type	Session Length/ Frequency
2nd Grade					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
Name of School:					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
3rd Grade					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
Name of School:					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
4th Grade					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
Name of School:					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
5th Grade					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
Name of School:					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
6th Grade					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
Name of School:					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK

School Year	Type of School (✓ one)		Type of Class (✓ one)		Special Services (Please check all that apply)		
	Regular	Special	Regular	Special	Service	Type	Session Length/ Frequency
7th Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
8th Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
9th Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
10th Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
11th Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK

School Year	Type of School (✓ one)		Type of Class (✓ one)		Special Services (Please check all that apply)		
	Regular	Special	Regular	Special	Service	Type	Session Length/ Frequency
12th Grade					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
Name of School:					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK

BACKGROUND INFORMATION ON YOUR CHILD:

1. Ethnicity:
    1. _____ White
    2. _____ Black
    3. _____ Hispanic
    4. _____ Asian
    5. _____ Other, please specify: ____

2. With whom does the child currently live? (Check **ALL** that apply)

_____ biological mother
_____ biological father
_____ adoptive mother
_____ adoptive father
_____ step-mother or father's companion
_____ step-father or mother's companion
_____ foster mother
_____ foster father
_____ other relatives
_____ other non-relatives
_____ other (who? ______________________________)

3. Marital Status of BIOLOGICAL PARENTS: (Check **ALL** that apply)

_____ married
_____ living together
_____ never married
_____ separated
_____ divorced
_____ mother remarried
_____ father remarried
_____ mother deceased
_____ father deceased

4. List **ALL** children (including patient) in order of birth. *(Please include last name, if different from referred child's)*

NAME	DOB	GRADE	Lives at home? Y/N	Same biological Mother? Y/N	Same biological Father? Y/N	Any developmental delays? If yes, indicate type of delays Y/N
_________________________	___/___/___	_____	___	___	___	__________________________
_________________________	___/___/___	_____	___	___	___	__________________________
_________________________	___/___/___	_____	___	___	___	__________________________
_________________________	___/___/___	_____	___	___	___	__________________________

PARENT/CAREGIVER INFORMATION

NOTE: If you don't know the answer to any of these questions, please indicate this by entering "DK"

1. Mother's Name (first/Last): ____

   Date of Birth (Mo/Day/Yr): ___/___/___ Telephone #: ( ) ______________________

   Address (if different from child's):

   ____

   ____

   Present Occupation: ______________________________ Full Time / Part Time (circle)

   Name of Employer: ____

   Telephone # at work: ( ) ______________________

   Ethnicity:

   1. _____ White
   2. _____ Black
   3. _____ Hispanic
   4. _____ Asian
   5. _____ Other, please specify: ______________________________

2. Father's Name (first/Last):____

   Date of Birth (Mo/Day/Yr): ___/___/___ Telephone #: ( ) ______________________

   Address (if different from child's):

   ____

   ____

   Present Occupation: ______________________________ Full Time / Part Time (circle)

   Name of Employer: ____

   Telephone # at work: ( ) ______________________

   Ethnicity:

   1. _____ White
   2. _____ Black
   3. _____ Hispanic
   4. _____ Asian
   5. _____ Other, please specify: ______________________________

3. Highest level of education:

	Mother	Father
1. 8th grade or less	_____	_____
2. some high school	_____	_____
3. high school graduate	_____	_____
4. some college	_____	_____
5. college degree	_____	_____
6. master's degree	_____	_____
7. doctoral degree	_____	_____

4. Family Income: (Please check one)

1. Less than $10,000/year	_____
2. $10,000 – 20,000/year	_____
3. $20,001 – 40,000/year	_____
4. $40,001 – 70,000/year	_____
5. $70,001 – 100,000/year	_____
6. $100,001 or more/year	_____

FAMILY HISTORY

To your knowledge, have your or any members of the child's family (that is, parents, other children, aunts, uncles, or grandparents on either side) ever had any of the following problems? Is so, *please specify the person's relationship to the child, e.g., aunt, uncle) and whether the individual was on the mother's or father's side of the family.*

	Relationship to Child	Mother's Side	Father's Side
Autism spectrum disorder	______________________________	________	________
Specify if known:			
Autism	______________________________	________	________
Asperger's disorder	______________________________	________	________
PDD-NOS	______________________________	________	________
Mental retardation	______________________________	________	________
Learning disabilities	______________________________	________	________
Hyperactivity (Attention Deficit Disorder)	______________________________	________	________
Bipolar (manic depressive)	______________________________	________	________
Alcoholism	______________________________	________	________
Nervous Breakdown	______________________________	________	________
Epilepsy	______________________________	________	________
Drug Abuse	______________________________	________	________
Depression	______________________________	________	________
Severe mood swings	______________________________	________	________
Psychiatric hospitalization	______________________________	________	________
Committed a serious crime	______________________________	________	________
Schizophrenia	______________________________	________	________
Severe anxiety	______________________________	________	________
Other (describe)	______________________________	________	________
	______________________________	________	________
	______________________________	________	________

SLEEP FUNCTIONING

Does your child currently have any sleep difficulties? _____Yes ____No
If yes, please describe ____
____

Does your child experience any of the following (check all that apply):
___Difficulty falling asleep ___Bedwetting
___Difficulty staying asleep ___Nightmares
___Waking too early

Does your child need medication to sleep? ____ Yes ____No
If yes, what kind? ____

Does your child use technology right before bed? ____Yes ____No

Are any of the following in your child's room? ___ TV ___Phone ___iPad ___Video Games ___Other

How many hours a day does your child spend on technology? _____ hours

Times of the day your child is on your technology? ___Morning ___After School ___Evening ___Before Bed

Do you keep track of your child's internet activity? ____Yes ____No

What websites does your child most frequently visit? ______________________________________

Did (does) your child have any of the following difficulties with the development of speech and language skills?
(**PLEASE CHECK ALL THAT APPLY**)

SKILL	IN THE PAST	AT PRESENT
___ NO DIFFICULTIES	☐	☐
___ NON-VERBAL	☐	☐
___ BABBLES WITHOUT INTENT TO COMMUNICATE	☐	☐
___ DELAY IN SPEECH DEVELOPMENT	☐	☐
___ REPEATS WORDS/PHRASES OUT OF CONTEXT	☐	☐
___ ECHOLALIC (REPEATS WHAT OTHERS SAY/REPEATS QUESTIONS ASKED RATHER THAN ANSWER THEM)	☐	☐
___ SEEMS TO HAVE A MADE-UP LANGUAGE OR USES MADE UP WORDS	☐	☐
___ PRONOUN REVERSAL ("YOU" INSTEAD OF "I", ETC.)	☐	☐
___ MONOTONE, ODD PITCH OR "SING SONG" VOICE	☐	☐
___ EXCESSIVE STAMMERING/STUTTERING	☐	☐
___ CAN'T STOP TALKING ABOUT CERTAIN TOPICS (PESEVERATES)	☐	☐
___ SPEAKS AS IF LECTURING OTHERS	☐	☐
___ PRACMATIC DIFFICULTIES (POOR EYE CONTACT, CAN'T MAINTAIN SOCIAL CONVERSATION)	☐	☐
___ DOESN'T USE FACIAL EXPRESSIONS THAT COMMUNICATE GUILT, SURPRISE, SADNESS, ETC.	☐	☐

SOCIAL FUNCTIONING

1. Did your child show an interest in playing "nursery games" such as peek-a-boo or patty cake? _____ NO (1) _____ YES (2)
2. Is your child interested in toys? _____ NO (1) _____ YES (2)
   IF YES, please indicate the child's favorite toys: ____
3. Was your child fascinated with lights, spinning objects, or parts of toys, such as caps, wheels, etc.?
4. Has your child developed symbolic (letting a common household item stand in for another item) make believe or pretend play skills? ____ NO (1) _____ YES (2)
   If YES, please provide examples:
   ____
   ____
5. Does (did) your child have any repetitive play skills (That is, does your child pay the same game or make believe story over and over, play with only one or two toys, etc.) _____ NO (1) _____ YES (2)
6. Is your child interested in other children's play? _____ NO (1) _____ YES (2)
7. Does your child have a best friend? _____ NO (1) _____ YES (2)
8. Does your child have any friends? _____ NO (1) _____ YES (2)
9. Would you describe your child as wanting friends, but lacking knowledge about how to make friends? _____ NO (1) _____ YES (2)
10. Does (did) your child imitate the behaviors of others? _____ NO (1) _____ YES (2)
11. Does (did) your child seem preoccupied with letters,numbers,maps,dialogue from movies, TV, videos, etc? _____ NO (1) _____ YES (2)
12. Does (did) your child have difficulty relating to peers? _____ NO (1) _____ YES (2)
13. Does your child try to dominate play with others? _____ NO (1) _____ YES (2)
14. Does (did) your child make inappropriate social gestures,such as biting,hitting,etc. to approach others? _____ NO (1) _____ YES (2)

BEHAVIORAL FUNCTIONING

Please check **ALL** of these items that apply to your child. Please provide an explanation of the behavior in the space provided.

BEHAVIOR	EXPLANATION OF BEHAVIOR
___ No behavior problems	____
___ Excessive tantrums	____
___ Upset by change	____
___ Difficulty with transitions	____
___ Becomes too interested in topics/items	____
___ Unaware of body in space/clumsy	____
___ Self-stimulatory behaviors (spins toys, flaps arms, waves toys in front of face, etc.)	____
___ Self-abusive behaviors	____
___ Routine-oriented (gets upset if daily routine changes)	____
___ Overly rigid or demanding	____
___ Ritualistic Behavior (repeats certain stereotypic behaviors over and over)	____
___Unusual interests (washing machines, vacuums, people's birthdays, etc)	____
___Repetitive play/actions	____
___Interested in smelling objects	____
___Interested in feeling/touching objects	____
___Mouths toys (puts toys in mouth)	____
___Withdraws from affection	____
___No reaction/over-reaction to pain	____
___Over-sensitive to sounds/lights	____
___Aggressive toward others	____
___Impulsive	____
___Overactive	____
___Poor attention span	____
___Seems emotionally distant	____
___Takes a person's hand/arm to get a desired object	____
___Seems to look through people as if they weren't there	____
___Very disorganized	____
___Sleeping problems	____
___Has a special skill	____

GENERAL LOSS OF SKILLS

Was there a period during which your child seemed to lose skills that s/he acquired earlier, other than during a physical illness?

_____ NO (1)   _____ YES (2)

IF SO, PLEASE COMPLETE THE FOLLOWING CHART:

SKILL	APPROXIMATE AGE OF LOSS OF SKILL	WAS LOSS OF SKILL ASSOCIATED WITH A PHYSICAL ILLNESS?
_____ COMMUNICATION		_____ NO (1) _____ YES (2)
_____ SOCIAL INTERACTION & RESPONSIVENESS		_____ NO (1) _____ YES (2)
_____ PLAY AND IMAGINATION		_____ NO (1) _____ YES (2)
_____ SELF CARE SKILLS (GROOMING, EATING, ETC.		_____ NO (1) _____ YES (2)
_____ ACADEMIC OR VOCATIONAL SKILLS		_____ NO (1) _____ YES (2)
_____ MOTOR SKILLS (COORDINATION)		_____ NO (1) _____ YES (2)
_____ TOILET TRAINING (BLADDER)		_____ NO (1) _____ YES (2)
_____ TOILET TRAINING (BOWEL)		_____ NO (1) _____ YES (2)

PLEASE USE THIS PAGE FOR ANY ADDITIONAL INFORMATION YOU MAY FEEL IT'S IMPORTANT FOR US TO KNOW ABOUT YOUR CHILD