



**Northwest  
Pediatric Center**

# **ASD Parent Questionnaire**

## **ASD (Autism Spectrum Disorder)**

(Please complete this form using black ink)

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Parents' Name(s) \_\_\_\_\_

**Northwest Pediatric Center, Inc.**

**CENTRALIA**  
1911 Cooks Hill Road  
Centralia, WA 98531  
(360)-736-6778  
Fax (360)-736-6552

**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:** \_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_

**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-one aide
			Other (please specify):

6. Have any additional educational modifications been attempted?

Yes	No	When	Type of instructional modification
			Private tutoring
			Behavioral modification program

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.).

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

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**Current Behavioral Concerns**

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

2. Many children with autism have difficulties with eye contact. Have you noticed that your child has difficulties with eye contact?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Many children with autism have difficulties with social interaction. Have you noticed that your child has difficulties with social interaction?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Many children with autism have repetitive behaviors, like hand flapping, twirling, or spinning. Have you noticed that your child has any repetitive behaviors?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

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8. 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?

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9. Has your child ever experienced any emotional, physical, or sexual abuse?

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**Mood & Anxiety Concerns**

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. 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:

3. 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:

5. 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

When did these problems begin? Specify age: \_\_\_\_\_

Please describe YES answers above:

Other comments:

**Social Interactions**

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

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2. 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**

- Are you and the child's father (mother) married? If so, how long? \_\_\_\_\_
- Is your current spouse/significant other the child's biological parent? \_\_\_\_\_
- How would you describe your family household functioning (circle all that apply)?  
 Warm                      Friendly                      LovingCaring                      Stress-free  
 Supportive                      Chaotic                      in CrisisUnstable                      Stressful  
 Other: \_\_\_\_\_

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

Person's name	Age	Relationship to the child

5. Dad's job/place of employment: \_\_\_\_\_  
 Mom's job/place of employment: \_\_\_\_\_

Dad's highest education level: \_\_\_\_\_ Mom's highest education level: \_\_\_\_\_

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 (e.g., spanking)
		Give in to child
		Avoidance of child

9. 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):

- 10. What are your child's main hobbies and interests? \_\_\_\_\_  
\_\_\_\_\_
- 11. What does your child enjoy doing most? \_\_\_\_\_  
\_\_\_\_\_
- 12. What does your child *dislike* doing most? \_\_\_\_\_  
\_\_\_\_\_
- 13. What are your child's areas of greatest accomplishment? \_\_\_\_\_  
\_\_\_\_\_
- 14. How many hours a day does your child spend: On the computer: \_\_\_\_\_ Watching TV: \_\_\_\_\_  
Playing video games: \_\_\_\_\_ Reading: \_\_\_\_\_ Playing outdoors: \_\_\_\_\_

**Developmental Screen**

**Pregnancy**

1. Mom's age when child was born: \_\_\_\_\_ Duration of pregnancy (weeks): \_\_\_\_\_
2. Any health problems or infections with mom during pregnancy? If so, specify:  
\_\_\_\_\_
3. Medications taken by mother during pregnancy: \_\_\_\_\_
4. Smoking by mother during pregnancy? \_\_\_\_\_ if so, how many packs per day? \_\_\_\_\_
5. Drug use by mother during pregnancy? \_\_\_\_\_ If so, which drugs? \_\_\_\_\_  
\_\_\_\_\_
6. Alcohol use during pregnancy? \_\_\_\_\_ If so, how much/what kind? \_\_\_\_\_
6. 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 \_\_\_\_\_
4. Complications during delivery or afterwards? \_\_\_\_\_
5. Did infant require oxygen for more than 4 hours after delivery? \_\_\_\_\_
6. Did the infant have jaundice? \_\_\_\_\_ Did he/she require phototherapy? \_\_\_\_\_
7. Did the infant have an infection? \_\_\_\_\_
8. Number of days infant was hospitalized after delivery: \_\_\_\_\_
9. 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 they 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): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. When was the onset of any chronic illness? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. 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)

5. 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

6. 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)

7. Is there any suspicion of alcohol or drug use? \_\_\_\_\_

8. Does your child have any problems sleeping? \_\_\_\_\_

Is there a TV in your child's bedroom? YES / NO      Does the child sleep by himself? YES / NO  
 What is your child's bedtime? \_\_\_\_\_ when does he/she actually fall asleep? \_\_\_\_\_  
 What time does your child wake on school days? \_\_\_\_\_ On weekends? \_\_\_\_\_  
 Does your child snore? YES / NO Does your child's sleep restless? YES / NO

9. Does your child have any problems with bed-wetting or having bowel movements in his/her pants?  
 \_\_\_\_\_  
 \_\_\_\_\_

**Treatment History**

1. List names and addresses of all other professionals who have seen your child for these concerns or referrals that are in place for your child around these concerns:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Dietary changes: \_\_\_\_\_ Supplements/Vitamins: \_\_\_\_\_

Natural remedies: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 G.mother	Paternal G.father	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):

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**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 G.mother	Maternal G.father	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):

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**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):

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*Thank you! Please return these papers and other Autism forms to:*

Northwest Pediatric Center, 1911 Cooks Hill Road, Centralia, WA 98531.