The University of Florida
Department of Psychiatry
Division of Child and Adolescent Psychiatry
AUTISM PROGRAM QUESTIONNAIRE

YOUR CHILD'S NAME: _____NICKNAME:_____

DATE OF BIRTH:_____AGE:_____

ADDRESS_____

YOUR TELEPHONE (S)_____

DATE QUESTOINNAIRE COMPLETED: _____

COMPLETED BY:_____RELATIONSHIP:_____

Who referred you to us?_____Why?_____

_____

Information about the Child and Family

Child's Sex: Male_____ Female_____

Mother's Name:_____ Age:_____ Occupation:_____

Father's Name:_____Age:_____ Occupation:_____

Mother completed: High School_____ Some College_____ College Graduate_____

Father completed: High School_____ Some College_____ College Graduate_____

Parents are: Married_____ Divorced_____ Separated_____ Never Married_____

Child currently lives with:_____

Child's legal guardian (s):_____

Other children in the family:

NAME	Age	List any problems or special needs
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there other people in the home? YES_____NO_____What is their relationship to your child?_____

Are there pets in your home? YES____NO____Please list:_____

_____

Do you live in: ____an apartment_____mobile home____house

What is your child's current diagnosis?_____

Who made this diagnosis?_____What age was your child when the diagnosis was made?_____

PLEASE LIST YOUR CURRENT MAJOR CONCERNS ABOUT YOUR CHILD (tell us how we can help):

How old was your child when you first became concerned?_____

Please tell us what you noticed early on in your child's development:

	YES	NO
Does your child play with toys in typical ways? If no, please describe_____		
Does your child seem to focus on only certain parts of toys or objects?		
Does your child seem overly pre-occupied with certain objects, toys, videos, or subjects?		
Does your child have difficulty relating to people?		
Does your child emotionally overreact to certain situations?		
Does your child have good eye contact?		
Does your child look at objects out of the corner of his/her eyes?		
Does your child ever look at objects from unusual angles?		
Does your child ever engage in self-injurious behaviors (eg., headbanging, eye-poking, picking at skin, hitting himself)?		
Does your child ever show aggression to others?		
Does your child frequently have temper tantrums?		
Does your child walk on tiptoes?		
Does your child rock back and forth or side to side?		
Is your child overly active or underactive?		
Does your child frequently have trouble sleeping?		
Does your child ever seem depressed?		
Does your child ever threaten to harm himself/herself?		
Does your child cover his/her ears in response to certain sounds or for no apparent reason?		
Does your child ignore unusually loud noises (sirens, vacuum cleaner)?		
Is your child bothered by tags in his/her clothing?		
Does your child frequently smell, touch, or lick objects or people?		
Does your child ever eat things that are not food?		
Does your child ever pull out his/her hair?		
Does your child ever eat his/her own hair?		
Does your child collect certain things or objects?		
Does your child seem pre-occupied with turning over your furniture or turning objects upside-down?		
Does your child insist on cupboards and doors being all open or all closed?		
Does you child complain when he/she is injured		
Does your child seem overly fearful or lack safety awareness?		
Does your child have difficulty learning compared to other children the same age?		

	Yes	No
Does your child ever mimic, echo, or repeat previously heard words or phrases?		
Does your child ever repreat phrases from television commercials or videos over and over?		
Does your child ever act out portions of videos or TV shows over and over?		
Does your child become upset if routines are changed?		
Does your child do some things in the same way over and over again?		
Does your child seem interested in people?		
Does your child seem interested in peers?		
Is your child affectionate?		
Does your child form friendships?		
Does your child play with other children?		
Does your child prefer to be alone?		

Please list your child's previous psychiatric treatment below:

Inpatient:

Date	Facility	Reason for Admit	Diagnosis

Outpatient:

Date	Facility	Type of Tx	Frequency	Diagnosis	MD/ Case Manager

Please tell us about the medications and/or supplements that have been tried with your child in the past by completing the table below. Please circle your child's current medication.

Current Medication/ Supplement	Dose/Include Maximum Dose Tried	Date/Length of Trial	RESULTS/ Reason for stopping (side effects)
STIMULANTS			
Ritalin			
Concerta			
Dexedrine/Dextrost			
Adderall (XR)			
Clonidine/Clonidine GR			
Tenex			
Wellbutrin			
ANTIDEPRESSSANTS			
Buspar			
Prozac			
Celexa			
Paxil			
Zoloft			
Imipramine/Tofranil			
NEUROLEPTICS			
Risperdal			
Zyprexa			
Seroquel			
Geodon			
ANTICONVULSANTS/MOOD STABILIZERS			
Depakote			
Tegretol			
Neurontin			
Lamictal			
Phenobarbitol			
Dilantin			
Keppra			
Zonegran			
Lithium			
Topamax			
Other			
SUPPLEMENTS			
Multivitamin			
Vitamin B6			
Magnesium			
L-Carnitine			
Co-Enzyme Q-10			
Omega 3 Fatty acids (Fish oil, flaxseed oil)			
DMG			
Acidophilus			
Nystatin			
Casein-free/Glutein-			

Current Medication/ Supplement	Dose/Include Maximum Dose Tried	Date/Length of Trial	RESULTS/ Reason for stopping (side effects)
free diet			
Colostrum			
IV IG			
Secretin			
GABA			
SAMe			
Folic Acid			
Herbal preparations			
Homeopathic preparations			

Please tell us about your child's previous evaluations by completing the table below:

Testing	Date Done	Report Available (Y/N)	Diagnosis	Performed by/and Location
IQ Testing/ Psychological Eval.				
Achievement Testing/ Learning Disability				
Speech/Language Evaluation				
Audiology/Hearing				
Occupational Therapy				
Physical Therapy				
Neurologist Consult				
EEG				
MRI				
Genetics Doctor Consult				
Fragile X study				
Chromosome study				
Opthalmology				
GI Doctor Consult				
Functional Behavior Analysis Administered				
CARD (Center for Autism and Related Disorders) client				
General Labwork				
Urine Organic Acids/Serum Amino Acides				
Psychiatrist Eval.				
OTHER				

Please describe your child's medical history:

Allergies_____

Injuries/Illnesses: _____

Surgeries: _____

Hospitalizations: _____

VaccinationHx:_____

Unusual Reactions_____

Seizures_____

EEG (Brain Tracing)_____MRI (Brain Scan)_____

EKG (Heart Tracing)_____ECHOCARDIOGRAM (Heart Scan)_____

Pediatrician/Family Practitioner: _____

Has your child ever had any problems in the following areas (please describe):

Condition	Description
Eyes/vision	
Ear infections/hearing	
Sore throats/Strep throats/tonsillitis	
Sinus problems	
Recurrent cold/ Infections	
Asthma/breathing problems	
Eating/poor appetite	
Stomach problems/ nausea/vomiting/reflux	
Constipation/diarrhea	
Food allergies/ intolerance to baby formula	
Kidney problems/ urinary tract infections/ bedwetting	
Swelling in legs/ankles	
Heart trouble/ murmurs/irregular heart rate/valve problems	
High/ low blood pressure	
Shortness of breath	
Fainting spells	
Seizures	

Condition	Description
Head injuries/loss of consciousness	
Skin problems/ rashes/ pale or mottled skin coloring	
Unusual marks on skin	
Intolerance to cold or hot climates	
Dry Hair/brittle nails	
Hair loss/excessive hair growth	
Poor growth/short for age/thin	
Excessive growth/ overweight/ tall for age	
Joint pain/ hyperextendable joints	
Broken bones/curvature of the spine	
Small or large head size	
Thyroid condition	
Anemia/blood conditions	
Any traumatic injury	
Other:	

If you have additional comments, please add them in the space below:

PLEASE TELL US ABOUT YOUR CHILD'S DEVELOPMENT

PREGNANCY

Mother's age@ birth_____No. of Prior Pregnancies_____ No. of Prior Live Births_____

Weight gain_____Nausea/Vomiting_____Spotting_____

Infections_____Hypertension_____Diabetes_____

Medication (over the counter and prescriptions):_____

_____

Pre-natal Vitamins:_____Substance Use/Alcohol/Cigarette Use:_____

Other :_____

_____

Complication:_____

_____

Duration: Fullterm_____Premature_____Late_____

Did you receive medication during labor and delivery? YES_____ NO_____

If yes, describe:_____

BIRTH

Delivery was by: Csection:_____ Vaginal:_____ Forceps Used:_____

Birth Weight: _____

OtherComplications:_____

_____

Baby was : Jaundice:_____ Blue_____ Cord around Neck:_____ Breech:_____

How many days did you stay in the hospital before going home with the baby?_____

POSTNATAL:

First 2 weeks home were: GOOD_____ FAIR_____ POOR_____

PLEASE EXPLAIN:_____

Baby was: Breast fed_____ Bottle fed _____ Both_____

Baby: Gained weight____ Ate well____ Vomited _____ Cried Often____

Slept Well____ Slept Poorly____

What was your child like as an infant?_____

Did you feel a bond with your baby? YES____ NO_____

Did you experience any depression after your baby's birth? YES____ NO_____

DEVELOPMENTAL MILESTONES

What age was your child when he/she:

ACTIVITY	AGE	ACTIVITY	AGE
Sat alone		Talked (single word)	
TOILET TRAINING		Talked in phrases	
Dry days		Talked in sentences	
Dry nights		Echolalia (repeating words or sentences	
No accidents		Undressed without help	
Crawled		Dressed without help	
Walked		Brushed hair without help	
Rode a tricycle		Bathed without help	
Drank from a cup w/o spilling		Tied shoelaces	
Used a spoon		Brushed teeth without help	

	YES	NO
Has your child lost skills or stopped progressing in any of the above areas? If yes, please tell us more. _____		
How old was your child when skills were lost or stopped progressing?		
Was your child ill just prior to or at the time of the loss? If Yes, what was wrong? _____		
Tell us about your child's special skills or abilities. _____		
Does your child seem to have a knack for Music, Art, Math, Reading, Electronics, or Balance? Explain:_____		
Tell us how your child communicates to you currently:		
Does your child point to things?		
Does your child use picture exchange cards to communicate?		
Can your child follow a one-step command (eg.,bring mommy the ball) without you giving any visual cues (pointing)?		
Can your child follow a two-step command (eg., go in the bedroom and find your shoe) without you giving any visual cues (pointing)?		
Can strangers understand your child's speech?		
Does your child have trouble pronouncing certain letters?		
Can your child hold a conversation about a favorite topic for any length of time?		
Does your child seem overly sensitive to certain smells, textures of clothing or food, to lights, or to different sounds? If Yes, describe:_____		
Does your child prefer to have clothing or shoes off?		
Does your child ever use certain objects or use their own hands or fingers in unusual or odd ways? If yes, describe:_____		

Please tell us about your family's history by checking all that apply below:

Condition	Description
Learning Disabilities	
Drug/Alcohol abuse	
Autism	
Mental Retardation	
ADHD	
Tics/Tourettes	
Conduct Disorder	
Depression	
Anxiety Disorders	
Bipolar Disorder	
Suicide	
Psychiatric Hospitalizations	
Incarcerations	

If you have additional comments, please use the space provided below:

_____

_____

_____

Please tell us about your child's school history:

School:

Is your child currently enrolled in school? YES___NO___

Do you currently home school your child? YES___NO___

- Present School/Preschool/Daycare: _____
  Grade: _____Type of class: general LD EH EMH

How many children in your child's class?_____

How many classroom aides in your child's class?_____

School Performance_____

- Grades last report card: _____ Grade repeated?____
  If YES, which?_____

- Suspensions (number/reason): _____
- Expulsions: _____
- School refusals/ truancies: _____
- Previous school (recent school changes): _____
- Behavior problems in school:_____
  _____

	YES	NO
Are you happy with your child's current school placement?		
Do you feel that your child's class is meeting his educational needs?		
Do you have confidence in his teacher?		
Do you feel his class size is adequate to meet his educational needs?		
Do you routinely attend your child's IEP meetings?		
Would you find it helpful to have a professional attend these meetings with you?		
Do you have daily communication with your child's teacher?		
Do you have confidence that your child's teacher can handle behavioral problems?		
Are you confident that your child's teacher understands your child's disabilities?		
Do you feel that your child receives adequate individual attention in school?		
Does your child have a classroom aid assigned just to him/her?		
Have you home schooled your child in the past?		
Does your child ride the bus to school?		
Does your child attend any after school programs?		
Are there any after school programs available for your child?		
Does your child attend summer school?		
Is summer school available for your child?		
Have you ever had to take legal action against your child's school or school board? Have you ever had to take legal action against your child's school or school board?		

IF YOU ANSWERED **YES** TO ANY OF THE ABOVE QUESTIONS, PLEASE DESCRIBE BELOW:

_____

_____

_____

_____

WE WOULD LIKE TO KNOW HOW YOU ARE DOING:

	YES	NO
How many hours of uninterrupted sleep do you usually get each night?_____		
Does your child sleep with you?		
Most days do you feel: tired___ rested ___ exhausted___ full of energy____		
Do you have a physician for yourself?		
Do you have any current medical problems?		
If YES, please describe:		
Do you take prescription medication for any reason?		
Do you currently take a daily multi-vitamin?		
Do you eat regular meals?		
You engage in physical exercise or a relaxation activity: daily___ 1-2 times per wk___ hardly ever___ not at all____		
On most days your mood is: good___ fair___ not so good____		
How do you cope with stress? Pretty good___ fair___ not so good____		
Are there days when you feel overwhelmed?		
Do you have anyone you can depend on to help you with your child?		
Are you confident in your child's physician?		
Do you feel you can be honest and openly discuss your concerns about your child with his/her physician?		
Do you attend any support groups?		
Do you feel your psychological needs are met?		

If you would like to add anything, please do so in the space below:

_____

_____

_____

_____

_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. WE HOPE THAT THE INFORMATION YOU HAVE PROVIDED WILL HELP US TO BETTER UNDERSTAND YOUR CHILD AND PROVIDE YOUR FAMILY WITH THE BEST CARE.

THE UNIVERSITY OF FLORIDA AUTISM TEAM