Akron Children's Hospital

-Welcome to the NeuroDevelopmental Science Center-
Autism Diagnostic Clinic

You have requested information on our Autism Diagnostic Clinic. This clinic involves a psychologist and a speech and language pathologist. Enclosed you will find a Parent Intake Questionnaire and a Teacher Questionnaire. In order for your child to be considered for the Autism Diagnostic Clinic you must complete and return the enclosed forms. Please have at least one teacher complete the Teacher Questionnaire. If your child has an ETR, IEP, 504 Plan, Help Me Grow services, or any recent testing (such as a speech and language evaluation) we **must** also receive a copy of the most **current** reports. Once the information is completed, simply return the paperwork in the envelope provided. This can also be faxed to 330-543-6045. Once this information has been received back in our office, it will be reviewed by our clinic staff. If your child meets the required criteria and is an appropriate fit, we will contact you to schedule an appointment. If our clinic staff finds that your child would not be a candidate for our clinic, they will provide you with the most appropriate resources that can assist you.

If you have any questions regarding this, please contact our office at 330-543-8050 and ask for Autism Diagnostic Clinic scheduling staff.

Thank you!

AUTISM DIAGNOSTIC CLINIC
INTAKE QUESTIONNAIRE*

Confidential

Patient's Name: _____

Today's Date: _____ Current Age: _____

Child's Date of Birth: _____ Grade: _____

Gender: ☐ Female ☐ Male

Ethnicity: ☐ African-American ☐ Hispanic ☐ Caucasian ☐ Native American
☐ Asian ☐ Other: _____

Primary Language: ☐ English ☐ Other: _____

Address: _____ Day Phone: _____
_____ Evening Phone: _____

Form Completed By: _____ Relationship to Child: _____

Referral Information

What is your understanding of why this evaluation was requested?

_____
_____
_____
_____
_____
_____
_____
_____
_____

Has your child ever had psychological, developmental, or neuropsychological testing done before?

☐ No ☐ Yes (please send a copy of all reports with this questionnaire prior to your appointment)

Has your child ever had an Autism Spectrum Disorder/Autism evaluation before?

☐ No ☐ Yes (please send a copy of all reports with this questionnaire prior to your appointment)

Symptom Checklist

Below you will find a list of possible areas of development or behavior that may be of concern to you.

Please check one box to the right of each of item. **My child:**	**Never**	**Some -times**	**Often**	**Very Often**
1. Has trouble looking people in the eyes/making eye contact				
2. Does not point or use gestures to communicate needs (like which snack) or interests (like pointing out a toy on a shelf)				
3. Is not showing interest in interacting or making friends with other children				
4. Does not seek praise for accomplishments or to be proud				
5. Has trouble understanding other peoples' feelings or emotions				
6. Has trouble taking turns				
7. Is delayed with or does not talk and/or does not understand when other people talk				
8. Repeats back what has just been said instead of answering				
9. Recites language memorized from TV or movies				
10. Lacks pretend or creative play				
11. Does not play with toys the way they were made or stacks/lines up objects repetitively instead of playing with them				
12. Has trouble playing with other children his/her age				
13. Has an intense or overly-focused interest in certain topics or toys/objects				
14. Has significant need for specific routines or rituals that often have no real purpose				
15. Engages in repetitive movements like finger flicking, hand flapping, rocking, spinning, pacing, head banging or toe walking				
16. Has a preoccupation with parts of objects like spinning wheels or opening and closing doors				
17. Lack variation in pitch or tone of his/her voice (such as a mechanical quality), nasal sound, or an overly exaggerated inflection				
18. Use unusual voice volume (too loud/too soft) for the setting s/he is in				
19. Has sensory sensitivity to noises, smells, touch/texture (please circle)				
20. Has sensory seeking behavior such as wanting to touch, smell, or mouth objects				
21. Has difficulty with transitioning from one activity to another				
22. Has difficulty with change in routine				
23. Does not respond to his/her name				
24. Has a flat expression or does not use facial expressions to let you know how s/he is feeling				
25. (for older children) has difficulty understanding humor or sarcasm, is very literal				
26. (for older children) has difficulty taking turns during a conversation				

Please describe what symptoms or problems are of most concern to you:

Please describe when and how you first became aware of these difficulties and whether they have gotten worse over time:

_____

_____

_____

_____

Do both parents agree about the nature of your child's problems? ☐ Yes ☐ No

Mother's Education: _____ **Occupation**: _____

Father's Education: _____ **Occupation**: _____

Please list all of members of family (that is, parents & siblings)**:**

Name	Age	Relationship	Current health	How is the relationship?	Living with child?

Please list any other people who are living in the home with the child:

Developmental History

Pregnancy and Birth History:

Age of mother at delivery: _____ **Birth weight** (pounds & ounces)**:** _____

Delivery was: ☐ Vaginal ☐ Cesarean ☐ spontaneous ☐ induced

Baby was born: ☐ Full term ☐ Premature at _____ weeks gestation ☐ Post term at____ weeks
☐ Forceps used ☐ Vacuum extraction used

Were there any problems during the pregnancy or delivery? ☐ Yes ☐ No
If Yes, please describe: _____

_____

_____

Did mother use medications, alcohol, drugs smoke or have x-rays during pregnancy? ☐ Yes ☐ No
If Yes, please describe: _____

_____

Language and Hearing:

Do you have concerns about your child's hearing? _____yes _____no

Indicate your child's **main** communication method: ____pointing ____signing ____pulling to object ____crying ____noises/sounds ____words

At what age did your child first? *(Write "not yet" when appropriate.)*

_____make single sounds _____use single words _____combine words in short sentences

Did your child begin to use words and then stop? ___Yes ___No *If "yes," at what age?*_____

What concerns do you have about your child's speech, language, or hearing? _____

_____

_____

_____

Behavior:

Please describe your child's personality and temperament: _____

_____

_____

Do you, or anyone else, have any concerns with your child's behavior? ___Yes ___No *If "yes," please describe:* _____

_____

_____

What age level best describes your child's behavior?

_____acts younger than age _____acts age appropriate _____acts older than age

Please describe: _____

_____

Medical and Psychiatric History

Please list all illnesses, surgeries, and hospitalizations that your child has experienced:

Illness/Condition	Dates	Treatment

Does your child have any recurring pain? ☐ YES (please describe) ☐ NO

_____

_____

_____

Please list your child's current medications:

Medication	Amount	Taking Since?	Reason

Please list your child's past medications:

Medication	Amount	How Long?	Reason for stopping

Is your child allergic to latex? ☐ YES ☐ NO

Please indicate any other allergies: _____

_____

Note below if any of your child or your child's relatives have had any of the following conditions:

Condition	Child	Siblings (include half brothers and sisters)	Father's Family	Mother's Family
Attention-Deficit/ Hyperactivity Disorder (ADHD/ADD)				
Autism Spectrum Disorder				
Cerebral Palsy				
Developmental Delay				
Genetic/ Birth Defects				
Mental Retardation/ Intellectual Disability				
Speech/Language Difficulties				
Hearing Loss				
Visual Impairment				
Convulsions/Seizures				
Aggressive/Violent Behavior (e.g., Oppositional Defiant Disorder)				
Alcoholism/Substance Abuse				
Depression				
Anxiety/OCD				
Bipolar Disorder				
Schizophrenia				
School Difficulties (e.g. Math, Reading, Writing)				
Other - **specify**				

Please describe any other relevant family medical or psychiatric history:

Educational History

Is your child currently in school, preschool, or daycare? ___Yes ___No *If "yes," please complete the following:*

School	City/State	Class Placement (s)	Dates of Attendance

Are you satisfied with your child's current school placement? ___Yes ___No *Comments:*_____

Has your child experienced any school related problems? ___Yes ___No *If "yes," please explain:*_____

(if your child is 3 or older): Does your child have an Individualized Education Program (IEP)? ___Yes* ___No

***Please send a copy of your child's current IEP and ETR with your intake questionnaire.**

(if your child is under 3): Does your child current receive Help Me Grow Services? ___Yes* ____No

***Please send a copy of your child's current Help me Grow Plan with your intake questionnaire**.

Does your child currently receive therapy services outside of school? (speech, OT, PT, etc)? ___Yes ___No

*If "yes," please describe:*_____

***Please send a copy of any outside therapy evaluations with your intake questionnaire**.

Please list any special talents, interests, or hobbies that your child has:

Please describe your child's strengths:

Please add any additional information that you feel may be useful:

Please remember that it is very helpful to have previous testing reports and therapy evaluations prior to your child's appointment. When you send back this intake questionnaire, please include any of the following that may be applicable:

☐ Most Recent or current Individualized Education Program (IEP) or Help Me Grow Individualized Family Service Plan (IFSP) and most recent Evaluation Team Report (ETR or MFE)

☐ Previous Evaluations
--Psychology, IQ, or Developmental Evaluations
--Speech/Language Evaluations
--Occupational Therapy Evaluation
--Physical Therapy Evaluation
--Audiology or Hearing Evaluation
--Mental Health or Social Work Evaluation
--Recent Progress Notes from School or Therapists
--Genetic Testing

Thank you for taking the time to complete this questionnaire.
We look forward to meeting you and your child.

NeuroDevelopmental Science Center
William H. Considine Building
215 W. Bowery St., Akron, OH 44308
Phone: 330-543-8050
Fax: 330-543-6045

Akron Children's Hospital