

Thank you for your recent inquiry about the Greenwood Interprofessional Autism Center. Attached is our Greenwood Intake Packet as well as our Developmental History Form for Autism Spectrum Disorder. Please fill out both packets and return them with all required documents. In order to make sure that all information is current, it is our policy that the intake packet, developmental history form and all required documents must be returned within 90 days to place you/your child on our waitlist and/or scheduling you/your child for an Initial visit. You will not be placed on our waitlist or scheduled until all documents are received by Greenwood.

There are three Authorization of Release of Information (HIPAA) Forms at the end of the Greenwood Intake Packet. Please fill out one form for Medical, one form for School, and one for Therapy(s). If you/your child is currently enrolled in more than one Therapy, please print off an additional Authorization of Release of Information form and fill out the form for the additional Therapy(s).

Please note that our email system limits the total size of an email to 20 MB. When sending an email that is larger than 20 MB, including attachments, please divide the email between more than one email.

Disclaimer: Truman's email is HIPAA compliant. Please exercise caution when emailing personal health information from an account outside of Truman's organization.

If you have any questions, or need assistance, please reach out and I would be glad to assist you.

Thank you,

Christopher J. Maglio, Ph.D.
Licensed Psychologist/Health Service Provider

Developmental History Form (child)

Date Form Completed: _____ **Person Completing the Form:** _____
Name and relationship to client

Client's Name: _____ **Sex:** M / F **Date of Birth:** _____

Address: _____
Street City State Zip

Phone Number: _____ **Email Address:** _____

REASONS FOR EVALUATION

Please list the reason(s) the client is being referred for the evaluation:

1. _____

2. _____

3. _____

When did these problems begin?

What are your goals for this evaluation?

Has the client ever received the diagnosis of an autism spectrum disorder? Yes No

If yes, in what month & year _____ and by whom _____

FAMILY INFORMATION

Mother/Guardian Name: _____ **Education:** _____

Occupation: _____ Full-time Part-time

Father/Guardian Name: _____ **Education:** _____

Occupation: _____ Full-time Part-time

Parents are:

- Married
- Unmarried, Living Together
- Never Married, Living Together
- Separated
- Divorced
- Mother Deceased
- Father Deceased

Child lives with:

- Biological Mother
- Biological Father
- Step-parent
- Adoptive Parent (specify) _____
- Grandparent
- Legal Guardian (specify) _____
- Other (specify) _____

Sibling Information

Name of sibling	Sex	Age	Different Father?	Different Mother?	List any health/behavior/ learning problems	Lives with child?
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N

How well does your child get along with his/her siblings?
 Very Well Good Average Fair Poor

Is English the client's primary speaking language: Yes No

If no, what is the client's primary language: _____

What is the client's secondary language: _____

Child Care and Discipline

Who is primarily responsible for the client's care? Mother Father Both Other: _____

Who is mainly in charge of discipline in the home? Mother Father Both Other: _____

Please describe discipline techniques: _____

FAMILY PSYCHIATRIC HISTORY

CONDITION/DISORDER	MOTHER	FATHER	BROTHER	SISTER	GRANDPARENT	AUNT/ UNCLE	OTHER CLOSE RELATIVES
Alcoholism							
Anxiety							
ADHD/ADD							
Autism Spectrum Disorder							
Bipolar Disorder							
Depression							
Epilepsy/Seizure Disorder							
Genetic Condition							
Hospitalized for Emotional Problems							
Intellectual disability							
Jail Time/Incarceration							
Language disorder							
Learning Disability							
Motor or Vocal Tics							
Psychosis or Schizophrenia							
Special Education							
Substance Abuse							
Suicidal Ideation/Attempt							

PREGNANCY AND BIRTH HISTORY

Parental ages when client was born: Mom _____ Dad _____

Was this pregnancy full term? Yes No If not, how many weeks before or after the expected due date was the baby born? _____ weeks BEFORE AFTER due date

Pregnancy number: 1st, 2nd, 3rd, 4th, other _____ Totals: # of pregnancies _____ # of miscarriages _____

Was this a multiple birth? Yes No UK ; if yes: Twins Triplets Quadruplets

Were the babies identical? Yes No UK (unknown)

Please describe any problems that occurred during previous pregnancies (e.g., miscarriage, premature labor and delivery, etc.): _____

Mother's health during pregnancy:

- | | |
|--|---|
| <input type="checkbox"/> No health problems during pregnancy | <input type="checkbox"/> Health during pregnancy not known |
| <input type="checkbox"/> Poor weight gain | <input type="checkbox"/> Severe nausea { <input type="checkbox"/> with dehydration} |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Infections (Flu, measles, CMV) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Eclampsia/Toxemia |
| <input type="checkbox"/> Other (specify) _____ | <input type="checkbox"/> Rh (blood group) incompatibility |

List medications taken during this pregnancy: _____

Did the mother consume more than 2 glasses of alcohol a day during this pregnancy? Yes No

Did the mother smoke during pregnancy? Yes No

Did the mother consume illegal substances during the pregnancy? Yes No

Labor and Delivery:

- No problems during labor and delivery Not known

Please note whether any problems occurred during labor or delivery (all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Forceps Used |
| <input type="checkbox"/> Meconium staining | <input type="checkbox"/> Umbilical cord around baby's neck |
| <input type="checkbox"/> Fever or infection of mother | <input type="checkbox"/> Breathing difficulties of child |
| <input type="checkbox"/> Placenta previa or abruption | <input type="checkbox"/> Placenta (bag of water) broke more than 1 day before delivery |
| <input type="checkbox"/> Other (specify): _____ | |

Baby was born head first breech (feet first) vaginal Cesarean (Why? _____)

Birth weight _____ lbs _____ oz Length _____ in. (if known) Head circumference _____ in. (if known) Apgar Scores (if known): _____ at 1 min _____ at 5 min

Newborn period:

Was the child healthy as a newborn? Yes No If not, please describe the problems and treatment:

Was the child born with any birth defects? Yes No If yes, explain: _____

Did the child require treatment in a newborn intensive care unit? Yes (for _____ days) No

Did the baby require any special care immediately after birth? Yes No

If yes, ✓ all that apply

- Breathing problems (requiring oxygen ventilator (*with a tube in windpipe*)
- Placement in an incubator
- Blood transfusions
- Significant muscle weakness or paralysis
- Poor muscle tone
- Seizures
- Feeding difficulties
- Excessive sensitivity to noise/stimulation
- Jaundice treated with lights
- Infection
- Surgery (describe): _____

DEVELOPMENTAL HISTORY

Social Development

Did you notice any delays in the client's social development? Yes No

As an infant, did the client:

Enjoying cuddling? Yes No _____

Tend to be fussy/irritable? Yes No _____

Make appropriate eye contact? Yes No _____

Respond to his/her name? Yes No _____

In the first four years of life, were any special problems noted in the following areas?

If yes, please describe below:

Temper Tantrums Yes No _____

Separating from parents Yes No _____

Excessive crying Yes No _____

Playing with other children Yes No _____

Speech and Language Development

Did you notice any delays in the client's language development? Yes No

If yes, please specify: _____

Did the following milestones develop on time? Please specify age (year/month).

Show interest in sound (by 3 months) Yes No _____

Babbling (by 4 to 6 months) Yes No _____

Understanding words (by 6-11 months) Yes No _____

Speaking first words (by 12 months) Yes No _____

Speaking in short phrases (by 24 months) Yes No _____

Motor Development

Did you notice any delays in the client's motor development? Yes No

If yes, please specify: _____

Did the following milestones develop on time? Please specify age (year/month).

Turn over (by 6 months) Yes No _____

Sit alone (by 9-12 months) Yes No _____

Crawl (by 9-12 months) Yes No _____

Stand alone (by 9-12 months) Yes No _____

Walk alone (by 12-18 months) Yes No _____

Walk upstairs (by 36 months) Yes No _____

Walk downstairs (by 48 months) Yes No _____

Running Yes No _____

Which hand does the client use for writing or drawing? Right Left Both

Eating? Right Left Both

Throwing? Right Left Both

Daily Living

When was the client toilet trained? Days: _____ Nights: _____

Did bed-wetting occur after toilet training? Yes No If yes, until what age? _____

Did bed-soiling occur after toilet training? Yes No If yes, until what age? _____

Does your child have difficulty with sensory processing?

If yes, please describe below:

Tolerating Food Textures Yes No _____

Gagging or Vomiting Yes No _____

Tolerating Clothing Yes No _____

Tolerating Touch from Others Yes No _____

Does Not Notice Pain Yes No _____

Other _____

Has the client experienced a significant LOSS of an acquired skill or skills (not just a delay)?

For example, a child who was engaging in pretend play with other children for at least 4 to 6 months and then stopped and began just spinning, dropping, or throwing objects in his/her free time or speaking in full sentences for many months and then just stopped speaking altogether or began using only single words occasionally)

Social functioning Age of loss: _____ months; Explain: _____

Speech / language Age of loss: _____ months; Explain: _____

Problem solving Age of loss: _____ months; Explain: _____

Motor coordination Age of loss: _____ months; Explain: _____

Bladder/bowel control Age of loss: _____ months; Explain: _____

MEDICAL HISTORY

No serious illnesses or injuries in the **past** No serious illnesses or injuries **now**

Date	Age	Diagnosis/Illness	Past	No	Date	Age	Diagnosis/Illness	Past	No
		Serious Injuries	<input type="checkbox"/>	<input type="checkbox"/>			Lung/breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>
		Serious head injury	<input type="checkbox"/>	<input type="checkbox"/>			Asthma	<input type="checkbox"/>	<input type="checkbox"/>
		Other serious injury	<input type="checkbox"/>	<input type="checkbox"/>			Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
		Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>			Apnea or irregular breathing	<input type="checkbox"/>	<input type="checkbox"/>
		Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>			Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
		Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>			Stomach/bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>

		Birth abnormality	<input type="checkbox"/>	<input type="checkbox"/>			Swallowing problems	<input type="checkbox"/>	<input type="checkbox"/>
		Seizures (any type)	<input type="checkbox"/>	<input type="checkbox"/>			Gastroesophageal reflux	<input type="checkbox"/>	<input type="checkbox"/>
		Other: _____					Chronic abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
		Vision Problem	<input type="checkbox"/>	<input type="checkbox"/>			Chronic diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
		Vision problems at birth	<input type="checkbox"/>	<input type="checkbox"/>			Chronic constipation	<input type="checkbox"/>	<input type="checkbox"/>
		Requires glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>			Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			Kidney/Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
		Hearing Problem	<input type="checkbox"/>	<input type="checkbox"/>			Abnormalities at birth	<input type="checkbox"/>	<input type="checkbox"/>
		Hearing problems at birth	<input type="checkbox"/>	<input type="checkbox"/>			Kidney/bladder infections	<input type="checkbox"/>	<input type="checkbox"/>
		Deafness	<input type="checkbox"/>	<input type="checkbox"/>			Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
		Chronic ear infections	<input type="checkbox"/>	<input type="checkbox"/>			Muscle/bone/joint) Problems		
		Ear tubes	<input type="checkbox"/>	<input type="checkbox"/>			Abnormalities at birth	<input type="checkbox"/>	<input type="checkbox"/>
		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			Scoliosis or spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>
Date	Age	Diagnosis/Illness	Past	No	Date	Age	Diagnosis/Illness	Past	No
		Dental Problem	<input type="checkbox"/>	<input type="checkbox"/>			Circulatory Problem	<input type="checkbox"/>	<input type="checkbox"/>
		Abnormally shaped/ missing teeth	<input type="checkbox"/>	<input type="checkbox"/>			Anemia	<input type="checkbox"/>	<input type="checkbox"/>
		Extractions/cavities	<input type="checkbox"/>	<input type="checkbox"/>			Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>
		Dental braces	<input type="checkbox"/>	<input type="checkbox"/>			Chronic low platelet count	<input type="checkbox"/>	<input type="checkbox"/>
		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			Bleeding /bruising problem	<input type="checkbox"/>	<input type="checkbox"/>
		Skin Problem	<input type="checkbox"/>	<input type="checkbox"/>			Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
		Eczema	<input type="checkbox"/>	<input type="checkbox"/>			Hormone Problem	<input type="checkbox"/>	<input type="checkbox"/>
		Ash leaf patches	<input type="checkbox"/>	<input type="checkbox"/>			Sugar diabetes	<input type="checkbox"/>	<input type="checkbox"/>
		Café-au-lait spots	<input type="checkbox"/>	<input type="checkbox"/>			Early puberty	<input type="checkbox"/>	<input type="checkbox"/>
		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			Late or incomplete puberty	<input type="checkbox"/>	<input type="checkbox"/>
		Growth Problem	<input type="checkbox"/>	<input type="checkbox"/>			Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
		Failure to gain weight	<input type="checkbox"/>	<input type="checkbox"/>			Mental Health problem	<input type="checkbox"/>	<input type="checkbox"/>
		Obesity	<input type="checkbox"/>	<input type="checkbox"/>			ADHD	<input type="checkbox"/>	<input type="checkbox"/>
		Short stature	<input type="checkbox"/>	<input type="checkbox"/>			Oppositional defiant	<input type="checkbox"/>	<input type="checkbox"/>
		Tall stature	<input type="checkbox"/>	<input type="checkbox"/>			Anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>
		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			Obsessive-compulsive	<input type="checkbox"/>	<input type="checkbox"/>
		Heart Problem	<input type="checkbox"/>	<input type="checkbox"/>			Depression	<input type="checkbox"/>	<input type="checkbox"/>
		Heart abnormalities at birth	<input type="checkbox"/>	<input type="checkbox"/>			Bipolar disorder (manic-depressive)	<input type="checkbox"/>	<input type="checkbox"/>
		Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>			Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>

		Heart rhythm abnormalities	<input type="checkbox"/>	<input type="checkbox"/>			Tic disorder (e.g., Tourette)	<input type="checkbox"/>	<input type="checkbox"/>
		High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			Intellectual disability	<input type="checkbox"/>	<input type="checkbox"/>
		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			Eating disorder (e.g., anorexia)	<input type="checkbox"/>	<input type="checkbox"/>
							Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

I have confirmed with my child's Primary Care physician that his/her immunizations are up to date. Yes No
If no, explain: _____

Specialized neurological or genetic tests:

No neurological or genetic testing has been done

<input type="checkbox"/> If done	Date (if known) Month/Year	Test	Normal Result	Abnormal Result	Unknown Result
<input type="checkbox"/>		EEG (brain wave test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		CT scan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		MRI scan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		PET/SPECT/ scan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		Other scan (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		Chromosomal microarray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		Chromosomal analysis (karyotype)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		DNA testing for fragile X syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		Other genetic test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List all hospitalizations and surgeries for the client, include overnight stays (medical or behavioral)

No past hospitalizations or surgery

Reason for hospitalization/surgery	Age	Length of stay

Allergies (to medications, foods, environmental antigens, etc.)

No past or current allergies

Source (medication, food, etc.)	Nature of reaction (hives, trouble breathing, etc.)

Current Medications

- No medications taken **now** Medications are being taken now, but the names are not known

Medication	Dosage	Age at start	Reason for medication	Improved	
				<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/> Y	<input type="checkbox"/> N

Name of person prescribing the medications: _____

RESOURCES: Please indicate resources/services being received **now**

- No resources/services are being received now
- Early Intervention Services (Agency: _____)
- Speech/Language therapy
- Psychiatry services
- Psychological/Behavioral individual counseling/therapy
- Group therapy
- Physical therapy
- Occupational therapy
- Case management
- Behavior Specialist Consultant (BSC)
- ABA services
- Other: _____

EDUCATIONAL HISTORY

School name: _____ Phone: _____

Grade in school: _____ Teacher (or best contact): _____

Has the client ever repeated a grade? Yes No

Is the client currently on a formal education plan in school? Yes No

If yes, please check: IEP 504 Plan

What best describes the client's current educational program?

- Full time in a regular class
- Time split between regular and special education classes
- Special education class
- Aide/Paraprofessional or extra help
- Specialized school
- Home schooled

Please indicate the educational program in which the client participated during his/her school* years:

School Year	Type of School		Type of Class		<i>Any Special Services</i>		
	Regular*	Special	Regular*	Special*	Yes	No	Type
3-5 preschool							
Kindergarten							
1 st							
2 nd							
3 rd							
4 th							
5 th							
6 th							
7 th							
8 th							
9 th							
10 th							
11 th							
12 th							

* **REGULAR** school applies to public or private schools for children without disabilities.
SPECIAL school applies to any schools intended for children with disabilities

SOCIAL AND BEHAVIORAL FUNCTIONING

Peer Relationships

Please indicate how the client relates to peers:

- Has problems relating to other children
- Has difficulty making friends
- Fights frequently with peers (verbal fights)
- Fights frequently with peers (physical fights)
- Prefers playing with younger children
- Prefers playing with older children
- Prefers to play alone
- Has a best friend

What role does the client take in peer groups? Leader Follower Some of Each

How many friends does the client have? _____

Recreational Interests

What does the client enjoy?

- Sports _____
- Hobbies _____
- Other _____

What are the client's personal strengths?

What do you enjoy most about the client?

What are your hopes for the client's future?

Additional Questions

CURRENT CONCERNS

1. What are your current concerns (what led you to pursuing this evaluation)?

DEVELOPMENTAL HISTORY

1. Is there a family history of developmental or learning issues?
2. When did you first notice that your child's development seemed different from other children? Describe any concerns you had prior to age four.
3. Did your child ever stop talking? If yes, at what age? For how long?
4. Did you notice concerns regarding your child's vision? (general vision problems, eye contact, intense interest in mirrors/lights, holds objects close to eyes, stares off into space, unusual visual interest such as spinning or studying objects)
5. Did you notice concerns regarding your child's hearing? (failed screening, ear fluid/infections, concern about hearing impairment/deafness, covers ears when hearing everyday sounds, seems to hear better on some days)
6. Have you had any concerns regarding his or her motor skills? (awkward, delays in gross motor skills/ fine motor tasks, repetitive motor behaviors/spinning and finger posturing)

SOCIAL INTERACTION

1. Do you currently have any concerns about your child's behavior or social skills? If yes, what are your concerns? At what age did you first have concerns about your child's social skills?
2. How would you describe your child's ability to play/interact with other children his or her age? (initiating, playing parallel, perseverative interests)
3. Does your child have **more** difficulty making and keeping friends when compared to other children of your child's same age?
4. What types of activities does your child enjoy participating in? Does your child show an interest in being with other children? Does your child prefer interacting with adults?

5. How does your child express his/her emotions and feelings? Does your child use a typical range of facial expressions that are appropriate for the situation?
6. What calms your child down? Does your child seek you out for comfort when tired, upset or sick?
7. Does your child understand basic safety rules and concepts for his/her age? Does your child need **more** or the **same** amount of supervision than other children his/her age need?

COMMUNICATION

1. Is your child currently able to use their finger to point to something or to request something?
2. If you give your child one direction at a time, can he/she follow the direction? Can he/she follow a series of directions? Give examples.
3. How does your child communicate at home?
4. How does your child initiate conversations with family members? With adults? With other children?
5. Does your child
 - greet others
 - respond to greetings
 - make requests,
 - describe events
 - comment on activities
 - share information about thoughts/interests/feelings
 - ask for help
6. Does he or she appropriately engage in back-and-forth conversation with other people?
7. Does your child's voice sound like it lacks emotion or sounds monotone or has a melodic vocal (sing-song) intonation? Does your child speak using an unusual volume or pitch?
8. What gestures does your child use? (nod, wave, point, etc.)
9. Does your child have difficulty understanding nonverbal cues such as facial expressions or changes in vocal tone? Give an example.

10. Does your child repeat phrases or sentences heard in the past that have little or no relationship to the current situation?

12. Does your child ever pull you to a desired item or use your hand as a tool instead of talking?

13. Do you notice anything unusual about your child's language skills? (mixing up pronouns, persisting on certain topics, repeating scripts from television shows, etc.)

RESTRICTED, REPETITIVE, OR STEREOTYPED BEHAVIOR/INTERESTS/ACTIVITIES:

1. Have you noticed differences in how he or she responds to touch, sound, smells, or light? (licks, smells, sniffs inedible objects)

2. Do you have any concerns about your child's eating? (unusual cravings, picky eater, restricted preferences)?

3. Are there unusual behaviors that seem different from other children? (flapping arms, walking on tip-toes or in circles, rocking, rapid lunging, obsessed with routines, self-abusive behavior)?

4. Describe your child's favorite activities. What holds your child's attention? Does your child initiate these activities independently?

5. Do you have concerns about your child's activity level or attention span?

6. Does your child have any interests that seem unusual for his/her age or seem unusual in intensity?

7. Are there any unreasonable fears or unusual reactions to situations?

8. How does your child react to changes in daily routine or schedule? (appears anxious, easily upset, adjust if prepared ahead of time, responds negatively or with tantrums when given commands/requests/directions)

9. Does he or she appear overly concerned with order and routine in his/her play or daily activities (i.e., lining things up, needing things in a certain order)

10. Does he or she seem more interested in the parts of toys or objects than the actual toy?

11. Does your child frequently engage in one-sided conversations about favorite topics?

12. What kind of assistance does your child need in performing daily tasks? (dressing, bathing, taking care of belongings, playing with friends)

SKILL ACQUISITION:

1. Does your child have difficulty learning new skills?

2. Does your child demonstrate any unusual or seemingly advanced skills?

OTHER:

1. Is there any other information that might be helpful to share?