This form is to help us know about your child's health, and the treatments your child is receiving. The form should be filled in by the person who takes care of the child most of the time.

This questionnaire is designed so you can fill it in yourself. There is no right or wrong answer. Answer each question to the best of your ability.

A staff person will review the form with you after you are done. At that time please ask any questions you had while trying to complete this form. Also, let us know about health problems that were not covered on the form.

Please note that all information is kept strictly confidential.
ATN Registry
Parent Baseline Assessment

Date form completed: ___/___/___

How are you related to the child enrolled in the ATN?
☐ BIOLOGICAL MOTHER ☐ BIOLOGICAL FATHER ☐ OTHER

If OTHER, specify your relationship to the child: _____________________________

SECTION A: DEMOGRAPHICS

A1. Is the child’s date of birth available? ☐ No ☐ Yes

A2. Child’s birthday: MM DD YYYY OR Child’s age at consent: ______

A3. What is the child’s sex? ☐ Male ☐ Female

A4. What is the child’s ethnicity?
☐ Hispanic or Latino origin
☐ Non-Hispanic or Non-Latino origin
☐ Do not wish to provide

A5. What is the child’s race? (check all that apply)
☐ American Indian or Alaskan Native ☐ Caucasian/White ☐ Native Hawaiian or Other Pacific Island
☐ Asian ☐ Aboriginal Canadian ☐ Do not wish to provide
☐ Black or African American ☐ Black Canadian

A6. What is the highest grade you have completed?
☐ Less than 8th grade ☐ Bachelor’s Degree (BA, BS) ☐ Some college or AA Degree
☐ Some high school ☐ Post-Graduate Degree
☐ Finished high school (or GED) ☐ Do not wish to provide

A7. What is the highest grade completed by the second caregiver?
☐ Less than 8th grade ☐ Bachelor’s Degree (BA, BS) ☐ Some college or AA Degree
☐ Some high school ☐ Post-Graduate Degree ☐ Not applicable – no second caregiver
☐ Finished high school (or GED) ☐ Do not wish to provide

A8. Household income (check one):
☐ $0.00-$24,999 ☐ $75,000-$99,999
☐ $25,000-$49,999 ☐ $100,000+
☐ $50,000-$74,999 ☐ Do not wish to provide

ATN ID: ____________________________ Baseline

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A9. Type of Insurance (check all that apply):

- □ HMO/Managed care
- □ Private Insurance/Indemnity Plan
- □ Private Insurance/PPO
- □ Public Insurance
- □ Other, please specify: ____________________________

A10. Does the child have full or half blood brother(s) or sister(s) enrolled in the ATN Registry? □ Yes □ No

COMPLETED BY SITE STAFF
A10a. If Yes, what is the ATN ID # of the 1st sibling enrolled? □ □ □ □ □ □ □ □
SECTION B: HEALTH AND MENTAL HEALTH HISTORY

Please check Yes for all items that have been a problem for your child now or in the past.

B1. Headaches
B2. Vision problems
B3. Ear, nose and throat problems
B4. Dental problems
B5. Heart conditions
B6. Asthma or other lung problem
B7. Nausea/ Vomiting
B8. Reflux
B9. Diarrhea
B10. Constipation
B11. Stomach/ abdominal pain
B12. Feeding problem
B13. Kidney/ bladder/ genital problems
B14. Bone or joint problems
B15. Blood or anemia problems
B16. Skin conditions
B17. Endocrine or hormone problems
B18. Seizures
B19. Tics
B20. Allergies (food, medication, environmental):
B21. Genetic Disorder
B22. Loss of skills/ regression
B23. Depression
B24. Bipolar mood disorder
B25. Anxiety disorder
B26. Obsessive compulsive disorder (OCD)
B27. Attention Deficit Hyperactivity Disorder (ADHD)
B28. If other health condition, specify:
B29. Was your child born with any birth defects and/or genetic conditions not noted above? If Yes, specify:
SECTION C: CHILD'S SLEEP HABITS QUESTIONNAIRE
(CSHQ: PRESCHOOL AND SCHOOL-AGED, ABBREVIATED VERSION)
SURVEY CREATED BY: JUDITH OWENS, MD, MPH

Instructions:
The following statements are about your child's sleep habits and possible difficulties with sleep. Think about the past week in your child's life when answering the questions. If last week was unusual for a specific reason (such as your child had an ear infection and did not sleep well or the TV set was broken), choose the most recent typical week. Answer as follows:
- RARELY if something occurs never or 1 time during a week
- SOMETIMES if it occurs 2-4 times in a week
- USUALLY if something occurs 5 or more times in a week

Also, please indicate whether or not the sleep habit is a problem by checking "NO" or "YES". Please answer each question even if the question asked is not a problem for your child.

Bedtime Information

C1. During the week what time does your child usually go to sleep?
   Time: ___ : ___  am  pm
C2. During the week what time does your child usually wake up?
   Time: ___ : ___  am  pm
C3. On the weekend what time does your child usually go to sleep?
   Time: ___ : ___  am  pm
C4. On the weekend what time does your child usually wake up?
   Time: ___ : ___  am  pm

Please answer both questions for each item: a. How often? and b. Is it a problem?

<table>
<thead>
<tr>
<th>Item</th>
<th>a. How often?</th>
<th>b. Is it a problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td>C5.  Child goes to bed at the same time at night</td>
<td>RARELY (0-1)</td>
<td>SOME-TIMES (2-4)</td>
</tr>
<tr>
<td>C6.  Child falls asleep within 20 minutes after going to bed</td>
<td></td>
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<tr>
<td>C7.  Child falls asleep alone in own bed</td>
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<tr>
<td>C8.  Child falls asleep in parent's or sibling's bed</td>
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<tr>
<td>C9.  Child needs parent in the room to fall asleep</td>
<td></td>
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<tr>
<td>C10. Child struggles at bedtime (cries, refuses to stay in bed, etc.)</td>
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<tr>
<td>C11. Child is afraid of sleeping in the dark</td>
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</table>
ATN Registry
Parent Baseline Assessment

C12. Child is afraid of sleeping alone

Sleep Behavior

C13. Child’s usual amount of sleep each day (combining night time
sleep and naps):

___ Hours ___ Minutes

<table>
<thead>
<tr>
<th>a. How often?</th>
<th>b. Is it a problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td>RARELY (0-1)</td>
<td>SOME-TIMES (2-4)</td>
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</tbody>
</table>

C14. Child sleeps too little

C15. Child sleeps the right amount

C16. Child sleeps about the same amount each
day

C17. Child wets the bed at night

C18. Child talks during sleep

C19. Child is restless and moves a lot during
sleep

C20. Child sleepwalks during the night

C21. Child moves to someone else’s bed during
the night (parent, brother, sister, etc.)

C22. Child grinds teeth during sleep (your
dentist may have told you this)

C23. Child snores loudly

C24. Child seems to stop breathing during sleep

C25. Child snorts and/or gasps during sleep

C26. Child has trouble sleeping away from home
(visiting relatives, vacation, etc.)

C27. Child awakens during the night screaming,
sweating, and inconsolable

C28. Child awakens alarmed by a frightening
dream
### Waking During the Night

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<tbody>
<tr>
<td>C29. Child awakes once during the night</td>
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<tr>
<td>C30. Child awakes more than once during the night</td>
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<tr>
<td>C31. Write the number of minutes a night waking usually lasts: (If they do not wake during the night, please record 0 min.)</td>
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### Morning Waking/Daytime Sleepiness

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<tbody>
<tr>
<td>C32. Child wakes up by him/herself</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>C33. Child wakes up in negative mood</td>
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<tr>
<td>C34. Adults or siblings wake up child</td>
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<tr>
<td>C35. Child has difficulty getting out of bed in the morning</td>
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<tr>
<td>C36. Child takes a long time to become alert in the morning</td>
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<tr>
<td>C37. Child seems tired</td>
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<tbody>
<tr>
<td>Child has appeared very sleepy or fallen asleep during the following:</td>
<td>NOT SLEEPY</td>
<td>VERY SLEEPY</td>
</tr>
<tr>
<td>C38. Watching TV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C39. Riding in car</td>
<td></td>
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</tr>
</tbody>
</table>

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ATN ID: ____________

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Baseline:

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SECTION D: PARENTAL CONCERNS*
Check what concerns you have about your child now.

<p>| | |</p>
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<tbody>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>D1. Language use and understanding (doesn’t use words, has difficulty initiating conversations, etc.)</td>
<td></td>
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<tr>
<td>D2. Sleep problems</td>
<td></td>
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<tr>
<td>D3. Gastrointestinal (belly) problems (diarrhea, constipation, pain)</td>
<td></td>
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<tr>
<td>D4. Neurologic problems (seizures, tics)</td>
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<tr>
<td>D5. Anxiety (worries a lot)</td>
<td></td>
</tr>
<tr>
<td>D6. Sensory issues (reacts to lights, sounds, textures)</td>
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<tr>
<td>D7. Aggression (intentionally hits, bites others, etc.)</td>
<td></td>
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<tr>
<td>D8. Hyperactivity (constantly moving, restless, active)</td>
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<tr>
<td>D9. Attention span (has difficulty finishing a task, etc.)</td>
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<tr>
<td>D10. Mood swings (unpredictable changes between emotions)</td>
<td></td>
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<tr>
<td>D11. Eating problems</td>
<td></td>
</tr>
<tr>
<td>D12. Social interactions (prefers to be alone, has few friends)</td>
<td></td>
</tr>
<tr>
<td>D13. Repetitive thoughts and behaviors (rocks, spins, flaps hand(s), etc.)</td>
<td></td>
</tr>
<tr>
<td>D14. Self-injurious behavior (bangs head, pinches, bites, hits oneself, etc.)</td>
<td></td>
</tr>
<tr>
<td>D15. Has lost or seems to be losing skills that he/she previously had (motor, academic, language)</td>
<td></td>
</tr>
</tbody>
</table>

*Used with permission from Susan McGrew, MD
### Section E Behavioral / Educational Interventions

**E1. Does your child receive any behavioral or educational services?**
- [ ] Yes
- [x] No

**E1a. If Yes, please check which services your child has received in the last month.**

- [ ] Speech therapy
  - If yes, how many hours? ___ per:
    - [ ] week
    - [ ] month
    - [ ] year

- [ ] Occupational therapy
  - If yes, how many hours? ___ per:
    - [ ] week
    - [ ] month
    - [ ] year

- [ ] Physical therapy
  - If yes, how many hours? ___ per:
    - [ ] week
    - [ ] month
    - [ ] year

- [ ] Learning center/Resource room
  - If yes, how many hours? ___ per:
    - [ ] week
    - [ ] month
    - [ ] year

- [ ] Academic tutoring
  - If yes, how many hours? ___ per:
    - [ ] week
    - [ ] month
    - [ ] year

- [ ] Social skills training (individual, group)
  - If yes, how many hours? ___ per:
    - [ ] week
    - [ ] month
    - [ ] year

- [ ] Behavioral therapy (including ABA – Applied Behavioral Analysis, Lovaas, Discrete trial training)
  - If yes, how many hours? ___ per:
    - [ ] week
    - [ ] month
    - [ ] year

- [ ] Developmental, individual differences, relationship-based approach (DIR)/Floortime
  - If yes, how many hours? ___ per:
    - [ ] week
    - [ ] month
    - [ ] year

- [ ] Verbal behavior training
  - If yes, how many hours? ___ per:
    - [ ] week
    - [ ] month
    - [ ] year

- [ ] Family therapy
  - If yes, how many hours? ___ per:
    - [ ] week
    - [ ] month
    - [ ] year

- [ ] Autism school/ Special education school
  - If yes, how many hours? ___ per:
    - [ ] week
    - [ ] month
    - [ ] year

- [ ] Other, specify: __________________________
  - If yes, how many hours? ___ per:
    - [ ] week
    - [ ] month
    - [ ] year
SECTION F: COMPLEMENTARY/ALTERNATIVE MEDICINE (CAM) INTERVENTIONS

F1. Is your child receiving any complementary or alternative treatments?  □ No  □ Yes

F1a. If Yes, check all that apply:

- □ Chiropractics
- □ High dosing Vitamin B6 and magnesium
- □ Other vitamin supplements
- □ Probiotics
- □ Digestive enzymes
- □ Glutathione
- □ Amino Acids
- □ Essential fatty acids
- □ Gluten-free diet
- □ Casein-free diet
- □ No processed sugars
- □ Other, specify: __________________________

Additional comments: ____________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

END OF FORM