Section A: Parental Concerns *

For each behavior listed below, please check the box that describes the extent to which it has been a problem for you **WITHIN THE PAST MONTH**.

<table>
<thead>
<tr>
<th>Behavior Description</th>
<th>No Problem</th>
<th>Mild Problem</th>
<th>Moderate Problem</th>
<th>Severe Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1. Language use and understanding (doesn’t use words, has difficulty initiating conversations, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A2. Compulsive behaviors (completes routines always in the same manner)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A3. Anxiety (shows distress from new situations or crowds, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A4. Sensory issues (reacts to lights, sounds, textures, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A5. Sleep disturbance (does not fall asleep easily, wakes often, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A6. Aggression (intentionally hits, bites others, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A7. Hyperactivity (is constantly moving, running, jumping, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A8. Attention span (has difficulty finishing a task, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A9. Mood swings (has unpredictable changes between emotions)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A10. Eating habits (eats few foods/certain types of foods, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A11. Social interactions (prefers to be alone, has few friends, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A12. Self-stimulatory and repetitive behaviors (rocks, spins, flaps hand(s), etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A13. Self-injurious behavior (bangs head, pinches, bites, hits oneself, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A14. Has lost or seems to be losing skills that he/she previously had (motor, academic, language)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

* Used with permission from Susan McGrew, MD
### Section B: Behavioral/Education Interventions

**B1.** At the time of this visit, does your child receive school-based services?  □ No  □ Yes  
*If “Yes”, complete B1a-B1c.*  

<table>
<thead>
<tr>
<th>Type:</th>
<th>□ Public</th>
<th>□ Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Early Intervention/Early Child Special Education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Elementary School</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Middle School</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ High School</td>
<td></td>
</tr>
</tbody>
</table>

**B1c.** Setting (Check one only):  
- □ General Education only (no modifications)  
- □ General Education with in-class assistant  
- □ General Education with pull out  
- □ Self-contained classroom for children with special needs  
- □ Self-contained classroom for children with ASD  
- □ Other *(Specify: ____________________________)*

**B2.** Does your child receive other in-school services?  □ No  □ Yes  
*If “Yes”, check all that apply:*

- □ Learning center/Resource room  
- □ Speech therapy  
- □ Occupational therapy  
- □ Physical therapy  
- □ Social skills/friendship  
- □ Group counseling  
- □ Behavior consultation  
- □ Other  
  *If “Other”, specify: ____________________________*

**B3.** At the time of the visit does your child receive community-based services?  □ No  □ Yes  
*If “Yes”, check all that apply:*

- □ Speech therapy  
- □ Occupational therapy  
- □ Physical therapy  
- □ Academic tutoring  
- □ Social skills training (individual, group)  
- □ Behavior consultation  
- □ Family therapy  
- □ Individual therapy  
- □ Biofeedback  
- □ Other  
  *If “Other”, specify: ____________________________*
B4. At the time of the visit, does your child receive in-home therapy services? □ No □ Yes
   If “Yes”, complete B4a – B4c:

B4a. Check all that apply:

   □ Discrete trial training
   □ Pivotal response training
   □ Verbal behavior training
   □ Developmental, individual differences, relationship-based approach (DIR)/Floortime
   □ Son Rise program
   □ Relationship Development Intervention (RDI)
   □ Other
   If “Other”, specify: ________________________________________________

B4b. How many hours per week of in-home services does your child receive?
   ________ hrs/week

B4c. Who provides the services? (Check all that apply)

   □ Parents
   □ Other family members
   □ Friends
   □ Paid paraprofessional
   □ Licensed professional
   □ Board Certified Behavior Analyst (BCBA)

---

Section C: Dietary Information

C1. Is your child on a special diet? □ No □ Yes
   If yes, check all that apply:

   □ Gluten free diet
   □ Casein free diet
   □ Feingold diet
   □ No processed sugars
   □ No sugars or salicylates
   □ Other
   If “Other” specify: ________________________________________________
Section D: Complementary and Alternative Treatments

D1. Is your child receiving any complementary or alternative treatments? □ No  □ Yes
   If yes, check all that apply:

   - Acupuncture
   - Roling
   - Chiropractics
   - High dosing Vitamin B6 and magnesium
   - Other vitamin supplements
   - Probiotics
   - Antifungals
   - Digestive enzymes
   - Chelation
   - Glutathione
   - Sulfation
   - Amino Acids
   - Essential fatty acids
   - Hyperbaric oxygen
   - Other

   If "Other", specify: __________________________
Section E: Hospitalizations

E1. Is this your child's first time to see this doctor or nurse after signing the ATN consent?
   □ No  □ Yes  □ Unsure

E2. If "No", has your child been admitted to the hospital or had surgery since the last visit?
   □ No  □ Yes  □ Unsure
   If yes, record from most the recent hospitalization backwards. If your child has been
   hospitalized more than 3 times since the last visit, please only include the 3 most recent
   incidents.

   Hospitalization 1:
   a. Date of Hospitalization: ___/___/____
   b. Reason: __________________________________________
   c. # of days hospitalized: ______________________

   Hospitalization 2:
   a. Date of Hospitalization: ___/___/____
   b. Reason: __________________________________________
   c. # of days hospitalized: ______________________

   Hospitalization 3:
   a. Date of Hospitalization: ___/___/____
   b. Reason: __________________________________________
   c. # of days hospitalized: ______________________

Thank you for completing this questionnaire. (END OF FORM)