ASD SOCIAL DEVELOPMENTAL HISTORY QUESTIONNAIRE

I. General Information

Person providing information / filling out form:

Relationship to child

Who does the child live with:

- ☐ Both Parents
- ☐ Mother
- ☐ Father
- ☐ Other

Father/Guardian's Name

Mother/Guardian's Name

Are there other adults who have a significant part in raising your child?

- ○ Yes
- ○ No

Have there been any significant changes in the home over the last few years? (Such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, parent job change, money problems, etc.)?

Language(s) spoken at home

Primary Language spoken at home

What is your child's primary communication modality?

- ○ ASL/Sign
- ○ Voice
- ○ Both Equally

Please describe your child's strengths:

Please describe your child's weaknesses:

Briefly describe your concerns for your child, if any:

Is your child:

- Biological Child
- Foster Child
- Adopted Child
- Other

If other, please explain

If adopted, please state the age of the child when adopted:

If the child was in foster care, please list: DHS Caseworker

DHS Caseworker Phone #

Please state length of time in foster care

II. Health and Development

Medication and medical problems will be noted on the Medical History forms

A. Pregnancy and Birth

How many weeks/months did the pregnancy last?

Child's birth weight: (pounds, ounces)

While the mother was pregnant with this child, were there any problems?

- Yes
- No

If yes, please explain

If there were any complications noted during or following delivery for the mother or baby, please explain:

Did the child go home from the hospital at the same time as the mother?

- Yes
- No

B. Hearing Information

Newborn Hearing Screening:

- Passed
- Failed
- Don't Recall

Approximate date of identification of deafness/hard of hearing:

Time of Onset:

- Birth
- First year of life
- 2nd or 3rd year of life
- 3 years or older

Please select:

- Unilateral Loss
- Bilateral Loss
- Sensorineural
- Conductive
- Mixed
- Mild
- Moderate
- Severe
- Profound

Is there a family history of deafness/hard of hearing?

- Yes
- No

Last audiogram date?

Last audiogram conducted where?

- ASD
- Other Clinic

Does your child use hearing aids?

- Yes
- No

Does your child have a cochlear implant?

- Yes
- No

Date/Age of child when amplification began?

Has your child used amplification in the past, but is currently a non-user?

- Yes
- No

C. Development

Please indicate the age or range when your child performed the following developmental milestones. If you are not certain of exact age, please provide an estimate:

Age child crawled

Age child walked alone

Age child spoke/signed first word

Age child spoke/signed words together

Age child became toilet trained

D. Health

Describe the state of your child's current health:

- Excellent
- Good
- Fair
- Poor

Has your child ever been identified as having a disability?

- Yes
- No

Please share any family history of disability diagnoses or mental health diagnoses:

Has your child ever received psychological counseling?

- Yes
- No

Vision checked (date and results)

III. Behavior

Please check the positive characteristics that apply to your child:

- Puts forth good effort
- Attentive
- Persistent in efforts
- Seeks help when necessary
- Gets along well with siblings
- Gets along well with peers
- Makes friends easily
- Wishes to please
- Listens appropriately
- Follows household rules
- Cooperative
- Gets along well with parents
- Helpful
- Other

If Other, please explain

Please check any of the following characteristics that apply to your child:

- ☐ Easily distracted
- ☐ Overactive
- ☐ Poor concentration
- ☐ Difficulty completing tasks
- ☐ Has sleeping problems
- ☐ Seems unhappy
- ☐ Tires easily
- ☐ Low self esteem
- ☐ Has poor coordination and balance
- ☐ Rocking
- ☐ Bed wetting
- ☐ Inattentive
- ☐ Quick to anger/temper tantrums
- ☐ Loses things, is disorganized
- ☐ Difficulty following instructions
- ☐ Cries easily
- ☐ Lacks energy
- ☐ Withdrawn
- ☐ Easily frustrated
- ☐ Trouble adjusting to new situations or people
- ☐ Head bumping
- ☐ Sensory seeking (chews, spins)

Please briefly explain any checked items

Has your child ever been suspended or expelled from school?

- ○ Yes
- ○ No

IV. Educational History

How does your child feel about school?

- ○ Likes
- ○ Dislikes
- ○ Is Indifferent

Can your child effectively express him/herself to you?

- Yes
- No

Has your child ever received speech therapy?

- Yes
- No

Has your child ever received occupational or physical therapy?

- Yes
- No

Has your child ever been retained?

- Yes
- No

Has your child been formally evaluated other than at ASD?

- Yes
- No

Attended an early intervention/preschool program?

- Yes
- No

Please list any other schools your child has attended since kindergarten

Parent/Guardian Name/E-signature

☐ Parent acknowledgement

Clear Form