Parent Questionnaire

Student’s name _____________________________ D.O.B. __________
School district ____________________________ Sex ________
Person completing form ______________________ Date ________
Address ____________________________________ Phone ________
City/state ________________________________ Zip ________
Mother ________________________________
Father ________________________________
Address (if different than person completing the form)
__________________________________________ Phone ________
City/state __________________________________ Zip ________

Names of Siblings*      Sex | Age | Grade | Living in Home?
---------------------------------------|-----|------|------------------

*If the child is a twin, please note by marking an asterisk by the name of the twin.

Thank you for completing this questionnaire!

Thank you for taking time to answer these questions. This may seem like a lot of questions, and you may not remember exact dates some things happened. Just do your best. Your answers will help the school determine how best to teach your child. Thanks again for your time.
1. Were academic difficulties or special problems experienced by brothers or sisters?  ☐ Yes ☐ No
   If yes, explain.
   ________________________________________________________________
   ________________________________________________________________

2. Are there other adults or relatives in the home? Give relationship:
   ________________________________________________________________
   ________________________________________________________________

3. What language is spoken in the home?
   ________________________________________________________________

4. In your own words, describe your child’s problem.
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

5. What is your greatest concern about your child?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

6. Child’s birth was:  ☐ normal ☐ premature ☐ overdue
7. Delivery was:  ☐ normal ☐ instrument ☐ cesarean
8. Weight at birth was: _____ lbs. _____ oz.
9. Health of child at birth:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

10. Mother’s health during pregnancy was:  ☐ good ☐ fair ☐ poor
11. History of birth injury:
   ________________________________________________________________
   ________________________________________________________________

12. Describe your child as a baby (e.g., a good baby, cranky, colicky, slept a lot, easy to hold, stiff).
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
13. Has your child had difficulties since birth or soon after?  

- Yes  
- No 

If yes, please describe:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

14. Did he or she stop developing at some point in time?  

- Yes  
- No 

15. If yes to question 14, what do you think might be the cause?
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

16. Is the child on any medication?  

- Yes  
- No 

17. If yes to question 16, please complete:

<table>
<thead>
<tr>
<th>Types of Medication</th>
<th>Reason Prescribed</th>
<th>Taken How Often?</th>
<th>Dosage</th>
<th>How Long on Medication?</th>
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18. Has your child suffered any head injuries?  

- Yes  
- No 

If yes, give details:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

19. Have you ever been concerned about your child’s behavior or speech and taken him or her to a doctor or other specialist for advice?  

- Yes  
- No 

If yes, please explain:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

20. Has a doctor or other specialist ever told you your child has a behavior or speech problem?  

- Yes  
- No 

If yes, please explain:
_____________________________________________________________________________
_____________________________________________________________________________
21. Have you ever been told by a doctor or other specialist that your child was hearing-impaired or deaf?  ❑ Yes  ❑ No

22. Has your child ever been hospitalized?  ❑ Yes  ❑ No If yes, explain:

______________________________________________________________________________
______________________________________________________________________________

23. Has your child had any of the following?

❑ Frequent ear infections    ❑ Allergies
❑ Frequent sinus infections  ❑ Seizures

24. Crawled for the first time:  ❑ at about the usual age OR _____ years _____ months

25. Walked alone:  ❑ at about the usual age OR _____ years _____ months

26. Does your child have an unusual gait or walk pattern (e.g., toe-walker)?  ❑ Yes  ❑ No
If yes, please describe:

______________________________________________________________________________
______________________________________________________________________________

27. Does your child show any of the following behaviors?

❑ Biting nails    ❑ Biting, hitting, or pinching self
❑ Twitching      ❑ Spinning
❑ Unusual hand/finger movements    ❑ Head banging
❑ Rocking        ❑ Fascination with moving or spinning objects

28. Does your child have any unusual reactions to any of the following? If yes, please explain:

❑ Sound ________________________________________________________________

❑ Smells ______________________________________________________________

❑ Things he or she sees __________________________________________________

❑ Touch _______________________________________________________________

❑ Taste ________________________________________________________________

29. Does your child have any other unusual reactions?

______________________________________________________________________________
______________________________________________________________________________

Introduction to Autism
30. How does your child handle transportation (e.g., rides easily, resistive)?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

31. To what degree is your child sensitive to pain?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

32. How does your child respond to affection (e.g., hugging, holding hands, patting)?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

33. Does your child give affection?  ❑ Yes  ❑ No  If yes, to whom?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

34. How does your child react to changes in the way things happen (e.g., changes in routine, different foods, different routes, new people)?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

35. Does your child have temper tantrums?  ❑ Yes  ❑ No
   If yes, how often? _____________________________________________________________
   How long are they? ___________________________________________________________
   Describe the intensity:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

36. Is your child destructive to self, others, or property?  ❑ Yes  ❑ No

37. Bladder control was achieved:  ❑ at about the usual age OR _____ years _____ months

38. Bowel control was achieved:  ❑ at about the usual age OR _____ years _____ months

39. Does your child have any unusual toileting behaviors?  ❑ Yes  ❑ No  If yes, please describe:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Introduction to Autism
40. Does your child make eye contact with people in the usual way? □ Yes □ No If no, explain:
______________________________________________________________________________
______________________________________________________________________________

41. Describe your child’s interaction with peers:
______________________________________________________________________________
______________________________________________________________________________

42. Do peers enjoy your child or merely tolerate him or her?
______________________________________________________________________________
______________________________________________________________________________

43. Describe your child’s interaction with family:
______________________________________________________________________________
______________________________________________________________________________

44. Describe your child’s interaction with adults:
______________________________________________________________________________
______________________________________________________________________________

45. Does your child get along with brothers and sisters? □ Yes □ No If no, please explain:
______________________________________________________________________________
______________________________________________________________________________

46. When left to play by him or herself, how does your child spend his or her time (i.e., unstructured situations)?
______________________________________________________________________________
______________________________________________________________________________

47. Does your child play with toys? □ Yes □ No If yes, what does he or she do with them? If no, what does he or she play with?
______________________________________________________________________________
______________________________________________________________________________
48. Does your child display unusual fascination with special objects, machinery, computers, etc.?
   Yes ☐ No ☐ If yes, describe:
   ____________________________________________________________
   ____________________________________________________________

49. Can your child be left with others (e.g., sitter, relatives)? Describe:
   ____________________________________________________________
   ____________________________________________________________

50. Is it difficult taking your child out in public places (e.g., church, shopping, movies, friends’ homes)? Explain:
   ____________________________________________________________
   ____________________________________________________________

51. Describe your child’s behavior activity and changes which might occur in various situations (e.g., changes in order of environment, moving furniture, someone visiting) and give examples:
   ____________________________________________________________
   ____________________________________________________________

52. Does your child seem to notice other people and/or different places? Explain:
   ____________________________________________________________
   ____________________________________________________________

53. Does your child talk? Yes ☐ No ☐ If yes, when were his or her first words spoken?
   ____________________________________________________________
   ____________________________________________________________

54. Is the speech unusual in any way (e.g., milestones, high pitched, off the subject, parrot-like, says some things over and over)? Yes ☐ No ☐ If yes, please explain:
   ____________________________________________________________
   ____________________________________________________________

55. How long does your child pay attention?
   ____________________________________________________________
   ____________________________________________________________

Introduction to Autism
56. Does he or she show independence or depend too much on others? Discuss:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

57. How does your child go about getting or doing what he or she wants (e.g., diplomatic maneuver, take forcibly, buy favors, tease, acting out)? Discuss:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

58. Does your child exhibit any outstanding qualities or talents (e.g., early reading, mathematic skills, outstanding memory, mechanical abilities, music, art, balance)? Explain:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

59. Does your child imitate others’ speech, repeating or parroting back the same words?

❑ Yes  ❑ No

60. If your child does not have speech, describe how he or she lets you know what he or she wants (e.g., communication boards, sign language, gestures):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

61. Does your child ask questions?  ❑ Yes  ❑ No

62. Does your child respond to questions?  ❑ Yes  ❑ No

63. Can nonfamily members understand what your child wants?  ❑ Yes  ❑ No

64. Does your child cry or laugh for little or no apparent reason?  ❑ Yes  ❑ No

65. Does your child display unusual fears?  ❑ Yes  ❑ No If so, describe:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

66. How does your child respond to dangerous situations (e.g., oncoming traffic, electric fan)?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
67. In what activities or areas is your child most successful?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

68. What have you done to assist, handle, or cope with your child’s problems?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

69. What disciplinary measures are used at home?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

70. What methods have you found most effective?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

71. Who administers them?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

72. Is the discipline consistent?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

73. When you are happiest with your child, what is he or she doing?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

74. In what activities or areas is your child least successful?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

75. Describe your child’s sleep patterns (e.g., sleeps at regular times, up all night):
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
76. Is there any other information that you think is pertinent which might be helpful?

______________________________________________________________________________

______________________________________________________________________________

77. What is your view of the future for your child? What do you want to see in the areas of education, vocation, living arrangements, etc.? Please discuss:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________