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PLEASE ANSWER ALL QUESTIONS REGARDING THE INDIVIDUAL WITH AUTISM

AUTISTIC INDIVIDUAL_____ AGE_____
ADDRESS_____CITY_____STATE____ZIP_____
NAME OF PERSON FILLING OUT QUESTIONNAIRE_____PHONE_____

SECTION A

Please explain any "yes" response and use reverse side for additional space.

1. Any problems with the pregnancy? Yes/No Explain:

2. Any difficulty with the birth? Yes/No Explain:

3. Any serious illness or disease? Yes/No Explain:

3a. Has your child had frequent infections, especially ear infections, which have been treated with broad spectrum antibiotics? Yes/No Explain

3b. Has your child had frequent infections with or without treatment with antibiotics? Yes/No Explain

4. Environmental allergies? Yes/No Explain:

5. Any food sensitivities? Yes/No Explain:

   Foods that cause problems talking, thinking or sitting still:

   Foods that cause fatigue or lethargy:

   Foods that cause stomachaches:

   Foods that cause headaches:

   Other problems:

6. Any sensitivity to certain smells such as hair sprays, perfumes, or detergents? Yes/No
   Explain:

7. Any problems if a meal is skipped?
   Headaches_____Dizzy_____Moody_____Stomachaches_____
   Active_____Tired ____Shaky _____Irritable_____Other_____

8. Any problems going to sleep or staying asleep? Yes/No Explain:

9. Sensitivity to certain clothing, fabrics, or textures? Yes/No Which ones?

10. Difficulty or resists wearing tight clothing? Yes/No Explain:

11. Reacts negatively or is sensitive to certain sounds? Yes/No Explain:

12. Is touch painful or bothersome? Yes/No Explain:

13. Circle the stimuli that appear bothersome, painful or aversive: Smells Sounds Touch Lights Patterns Textures Other (list)

14. Circle the stimuli which have a "mesmerizing" effect: Lights Colors Patterns Sparkles Textures Spinning Moving Other (list)

15. Is there a family history of autism? Yes/No Relationship

16. Is anyone in the family light sensitive? Is anyone bothered by sunlight, glare, or does anyone prefer to wear sunglasses outside? Yes/No Relationship

17. Does anyone in the family avoid reading or avoid reading for pleasure? Yes/No Relationship

18. Does anyone take breaks while reading or only read magazines or newspapers rather than preferring to read for an hour or longer at a time? Yes/No Relationship

19. Does anyone in the family have learning problems, ADHD, or dyslexia? Yes/No Relationship

20. Does anyone in the family have a history of headaches or migraines related to lights or reading? Yes/No Relationship

SECTION B

Circle the Yes or No or ?. Please explain any "yes" responses and use reverse side for more space.

1. Were there ever problems coloring and staying within the lines?	Yes/No/?
2. Were there ever problems being able to cut on a straight line?	**Yes/No/?**
3. Problems walking on straight lines on the floor?	Yes/No/?
4. Avoidance or trouble using revolving doors?	**Yes/No/?**
5. Difficulty or hesitation getting on or off moving things like an escalator?	Yes/No/?
6. Difficulty picking things up or putting them down?	**Yes/No/?**
7. Hesitation or fear going up or down stairs?	Yes/No/?
8. Difficulty catching balls?	**Yes/No/?**
9. Difficulty riding a bike?	Yes/No/?
10. Needs prompt to go down stairs?	**Yes/No/?**
11. Avoids automatic doors?	Yes/No/?
12. Acts calmer or prefers to be in dim lights?	**Yes/No/?**
13. Changes the brightness control on the TV?	Yes/No/?
14. Plays with the color control setting on the TV?	**Yes/No/?**
15. Squirms or becomes overactive under fluorescent lights?	Yes/No/?
16. Behavior changes under fluorescent lights?	Yes/No/?
17. Bothered by or dislikes certain colors?	Yes/No/?
18. Squints or closes one eye in bright light?	**Yes/No/?**

19. Likes to watch doors open and close?	Yes/No/?
20. Appears to stare at certain patterns or stripes?	**Yes/No/?**

SECTION C

CIRCLE Your Answer:	**NEVER**	**SOMETIMES**	**OFTEN**	**Don't Know**
1. Difficulty making eye contact?	0	1	2	?
2. Difficulty attending to and focusing on tasks?	0	1	2	?
3. Difficulty attending to toys and objects?	0	1	2	?
4. Stares into space?	0	1	2	?
5. Stares at or through people or objects?	0	1	2	?
6. Finger or hand stare?	0	1	2	?
7. Stares at lights, reflections or changing levels of illumination?	0	1	2	?
8. Focuses on the background rather than on The figure?	0	1	2	?
9. Distracted by visual stimuli in the environment?	0	1	2	?
10. Preoccupation with spinning, flipping or twirling objects?	0	1	2	?
11. Clumsy or awkward in movement?	0	1	2	?
12. Awkward when getting on or off equipment?	0	1	2	?
13. Falls or trips often?	0	1	2	?
14. Holds onto people, railings or walls?	0	1	2	?
15. Bumps into objects?	0	1	2	?
16. Has difficulty going through doorways?	0	1	2	?
17. Descends or ascends stairs or ramps without Alternating feet?	0	1	2	?
18. Exhibits hesitancy at stairs or ramps?	0	1	2	?
17. Exhibits atypical responses to visual stimuli In any manner other than listed?	0	1	2	?

SECTION D

CIRCLE Your Answer:	**NEVER**	**SOMETIMES**	**OFTEN**	**Don't Know**
1. Squints when asked to look at something?	0	1	2	?
2. Periodically blinks in a series ?	0	1	2	?
3. Looks at things in a series of short glances?	0	1	2	?
4. Identifies or repeats the name of something Being held for viewing but does not view it?	0	1	2	?
5. Shields one eye while sitting or walking?	0	1	2	?
6. Rubs or pushes on the eyes?	0	1	2	?
7. Views a scene by turning the head and Appears to stare?	0	1	2	?

8. Looks down or up at the ceiling while walking?	0	1	2	?
9. Looks through fingers?	0	1	2	?
10. Looks away from visual targets?	0	1	2	?
11. Appears startled when approached?	0	1	2	?
12. Startles when there is no apparent object?	0	1	2	?
13. Widens eyes or stares when looking at things?	0	1	2	?
14. Squirms or becomes overactive in bright lights?	0	1	2	?
15. Sits under shady trees when outside?	0	1	2	?
16. Preference for the lights dimmed or turned off?	0	1	2	?
17. Picks strange colors for the computer screen Or turns the brightness down?	0	1	2	?

SECTION E

CIRCLE Your Answer:	**NEVER**	**SOMETIMES**	**OFTEN**	**Don't Know**
1. When doing seat work or reading, Does your child lose his/her place?	0	1	2	?
2. Does your child have trouble copying from a book ?	0	1	2	?
3. Is copying from a chalkboard or white board difficult?	0	1	2	?
4. Does your child read better from flashcards Than a book?	0	1	2	?
5. Does your child rub his/her eyes, blink a lot Or move closer to the page when reading?	0	1	2	?
6. Is your child better at reading larger print?	0	1	2	?
7. When reading, does your child have difficulty Tracking from line to line?	0	1	2	?
8. When reading, does your child use a finger Or a marker?	0	1	2	?
9. When writing, is there unequal spacing between Words or letters?	0	1	2	?

SECTION F

1. Bothered by bright or fluorescent lights?	Yes/No/?
2. Do lights sometimes have halos, starbursts, or colors around them?	Yes/No/?
3. See little spots of brightness or colour?	Yes/No/?
4. Is it difficult to look at faces?	Yes/No/?
5. See colours when looking at things?	Yes/No/?
6. Do white pages look shiny, too "white" or bright?	Yes/No/?
7. Does it hurt to look at a white page?	Yes/No/?
8. Do things seem to be coming at you?	Yes/No/?
9. Is it hard to look at some stripes or patterns?	Yes/No/?
10. Dislikes or bothered by certain colors?	Yes/No/?

11. Squints or looks out of the side of your vision?	Yes/No/?
12. Is it difficult to look at people?	Yes/No/?
13. Is it difficult to look at things?	Yes/No/?
14. Do things appear to move or change such as: walls Stairs, wallpaper, furniture or carpet patterns?	Yes/No/?
15. Do things seem to appear and disappear?	Yes/No/?
16. Do things seem to fly apart?	Yes/No/?
17. Is it harder to understand what is seen or heard In rooms that have fluorescent or bright lights?	Yes/No/?
18. Is traveling in a car at times upsetting?	Yes/No/?
19. Is it difficult to play catch with a ball?	Yes/No/?
20. Negative reactions to stairs, escalators or driving?	Yes/No/?
21. Eyes feel tired when looking at pages with print on them while reading	Yes/No/?
22. Does it become hard to hear?	Yes/No/?
23. When things become hard to look at, Does it make it hard to hear?	Yes/No/?

SECTION G

CIRCLE the answer:	**NEVER**	**SOMETIMES**	**OFTEN**	**Don't Know**
1. When doing seat work, does your child lose his/her place or skip lines?	0	1	2	?
2. Does your child rub surfaces?	0	1	2	?
3. When writing, does your child use an atypical position or workpaper placement?	0	1	2	?
4. When reading or writing, does your child move back and forth?	0	1	2	?
5. Does your child choose the same coloured crayon, marker, or pen?	0	1	2	?
6. Does your child prefer coloured paper?	0	1	2	?
7. Does your child work quickly?	0	1	2	?
8. Is your child better at reading larger print?	0	1	2	?
9. Does your child read better from the blackboard or a vertical surface?	0	1	2	?
10. While reading, does your child say letters first instead of words?	0	1	2	?

11. Does your child misread words?	0	1	2	?
12. Does your child miss spaces between words, combining letters or words?	0	1	2	?
13. Does your child misunderstand or cannot follow directions?	0	1	2	?
14. When reading, does your child repeat words or lines?	0	1	2	?
15. When reading aloud, does your child skip words or lines?	0	1	2	?

SECTION H

- **Which of the following best describe your child (Choose all that apply)**
- Self-Stimulatory Behaviors
  - ☐ Rocks body
  - ☐ Wags head
  - ☐ Rotates or twirls body
  - ☐ Waves or flicks finger(s) near eyes
  - ☐ Paces
  - ☐ Walks running hand along wall
- Mode of Communication
  - ☐ Signing
  - ☐ One word/sign utterances
  - ☐ Two or three word/sign phrases
  - ☐ Simple sentences
  - ☐ Compound sentences
  - ☐ Complex sentences
  - ☐ Mechanized communication device (Specify device in space below

Please describe in detail the type of problems the autistic individual for whom you are filling out this questionnaire is having.

List any medical diagnosis and who provided the diagnosis:

DIAGNOSIS	YEAR	WHO PERFORMED TESTING