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.

Date form completed: ___ ___/___ ___/___ ___ ___ ___
M M D D Y Y Y Y

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: ☐☐ ☐☐ ☐☐☐☐ OR Child's age at consent: _____
MM DD YYYY

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

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.**

		No	Yes	Unsure
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

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

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

		a. How often?			b. Is it a problem?	
		RARELY (0-1)	SOME-TIMES (2-4)	USUALLY (5-7)	NO	YES
C5.	Child goes to bed at the same time at night	☐	☐	☐	☐	☐
C6.	Child falls asleep within 20 minutes after going to bed	☐	☐	☐	☐	☐
C7.	Child falls asleep alone in own bed	☐	☐	☐	☐	☐
C8.	Child falls asleep in parent's or sibling's bed	☐	☐	☐	☐	☐
C9.	Child needs parent in the room to fall asleep	☐	☐	☐	☐	☐
C10.	Child struggles at bedtime (cries, refuses to stay in bed, etc.)	☐	☐	☐	☐	☐
C11.	Child is afraid of sleeping in the dark	☐	☐	☐	☐	☐

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ATN ID: _____ *Baseline*

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

		a. How often?			b. Is it a problem?	
		RARELY (0-1)	SOME-TIMES (2-4)	USUALLY (5-7)	NO	YES
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	a. How often? RARELY (0-1)	SOME-TIMES (2-4)	USUALLY (5-7)	b. Is it a problem? NO	YES
C29. Child awakes once during the night	☐	☐	☐	☐	☐
C30. Child awakes more than once during the night	☐	☐	☐	☐	☐

C31. Write the number of minutes a night waking usually lasts:
(If they do not wake during the night, please record 0 min.) ___ ___ ___ minutes

Morning Waking/Daytime Sleepiness	a. How often? RARELY (0-1)	SOME-TIMES (2-4)	USUALLY (5-7)	b. Is it a problem? NO	YES
C32. Child wakes up by him/herself	☐	☐	☐	☐	☐
C33. Child wakes up in negative mood	☐	☐	☐	☐	☐
C34. Adults or siblings wake up child	☐	☐	☐	☐	☐
C35. Child has difficulty getting out of bed in the morning	☐	☐	☐	☐	☐
C36. Child takes a long time to become alert in the morning	☐	☐	☐	☐	☐
C37. Child seems tired	☐	☐	☐	☐	☐

Child has appeared very sleepy or fallen asleep during the following:	NOT SLEEPY	VERY SLEEPY	FALLS ASLEEP	NOT APPLICABLE
C38. ...watching TV	☐	☐	☐	☐
C39. ...riding in car	☐	☐	☐	☐

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

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

*Used with permission from Susan McGrew, MD

SECTION E BEHAVIORAL / EDUCATIONAL INTERVENTIONS

E1. Does your child receive any behavioral or educational services? ☐No ☐Yes

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