Parent/Guardian Instructions:

This covers a wide range of information regarding the medical history of you and your child. The questionnaire should only be completed by the child's primary caregiver (that is, the person who is responsible for taking care of the child most of the time). If you are not a primary caregiver, please let a staff member know and do not complete this questionnaire.

This questionnaire is designed so you can fill it in yourself. There are no right or wrong answers, but please answer each question to the best of your ability. You may want or need to check records that you have at home related to the birth and early examination of your child. You may choose not to answer questions that make you uncomfortable.

Once you have completed this form it will be reviewed with you by a staff person. At that time please ask any questions you had while trying to complete this form. Please feel free to raise any development or medical problems your child may have had that you feel are not covered adequately by the form.

Please note that all information is kept strictly confidential.

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ATN ID: __ __ __ __ __ __

Baseline Visit Only

Section A: KEY IDENTIFYING INFORMATION AND FAMILY BACKGROUND

A1. Date form completed .... ☐☐ ☐☐ ☐☐☐☐
mm dd yyyy

A2. Please indicate your relationship to the child:
☐ Biological mother
☐ Biological father
☐ Other

A2a. If "Other", specify:____

Section B: PREGNANCY HISTORY

B1. Is the pregnancy history of the biological mother available? ☐No ☐Yes
If "No", skip to C1

B1a. Please indicate the number of pregnancies of the biological mother: _____ _____

B1b. And the number of live births:___ ___

Section C: PREGNANCY & PERINATAL HISTORY

Instructions: Answer section C-G questions with respect to the pregnancy ***with the child.***

C1. Did the mother receive assisted reproductive technology? ☐No ☐Yes ☐Unsure

C2. Mother's age at birth of child : _________Years ☐Don't Know

C3. Father's age at birth of child : __________Years ☐Don't Know

Section D: ILLNESS/EVENTS DURING PREGNANCY

Please indicate whether the mother had any of the following illnesses/events during the pregnancy **with the child**:

D1. Fever over 101°F: ☐No ☐Yes ☐Unsure
(excluding those occurring during labor & delivery)

D2. Any infection: ☐No ☐Yes ☐Unsure

D3. Any other complication: ☐No ☐Yes ☐Unsure

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ATN ID: _ _ _ _ _ _

Section E: MEDICATIONS DURING PREGNANCY

E1. During this pregnancy, did the mother take any prescription medications? ☐No ☐Yes
If "Yes", complete the information below:

	Prescription Medication	No	Yes	Unsure
E1a.	Depakote: (Depakene, Valproic Acid)	☐	☐	☐
E1b.	Lithium:	☐	☐	☐
E1c.	Anti-epileptics or anti-seizures: (not including Depakote) e.g., Carbamazepine (Tegretol, Carbatrol), Gabapentin (Neurontin), Lamotrigine (Lamictal), Levetiracetam (Keppra), Oxcarbazepine (Trileptal), Phenobarbital, Phenytoin (Dilantin), Topiramate (Topamax)	☐	☐	☐
E1d.	Antidepressants: e.g., Amitriptyline (Elavil), Bupropion (Wellbutrin), Citalopram (Celexa), Escitalopram (Lexapro), Fluoxetine (Prozac), Fluvoxamine (Luvox), Imipramine (Tofranil), Paroxetine (Paxil), Sertraline (Zoloft), Venlafaxine (Effexor)	☐	☐	☐
E1e.	Mood stabilizers or antipsychotics: (not including Lithium) e.g., Carbamazepine (Carbatrol, Tegretol), Chlorpromazine (Thorazine), Gabapentin (Neurontin), Haloperidol (Haldol), Lamotrigine (Lamictal), Olanzapine (Zyprexa), Oxcarbazepine (Trileptal), Quetiapine (Seroquel), Risperidone (Risperdal), Thioridazine (Mellaril), Topiramate (Topamax)	☐	☐	☐
E1f.	Asthma medication: e.g., Fluticasone (Flovent), Budesonide (Pulmicort), Triamcinolone (Azmacort), Flunisolide (Aeobid), Beclomethasone (Qvar), Ipratropium (Atrovent), Salmterol (Serevent Diskus), Cromolyn (Latal), Formoterol (Foradil Aerolizer), Nedocrmi (Tilade), Montelukast (Singulair), Zafirlukast (Accolate)	☐	☐	☐
E1g.	Other: If "Other", specify:	☐	☐	☐

____

____

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Section F: PRE-NATAL SUBSTANCE USE

Note: Please be aware that all information shared is kept strictly confidential

During the pregnancy with the child, please identify whether the mother participated in any of the following activities:

F1. Alcohol Use: ☐No ☐Yes ☐Unsure

F2. Use of cigarettes or other tobacco products: ☐No ☐Yes ☐Unsure

F3. Other substance use, specify: ____________________ ☐No ☐Yes ☐Unsure

Section G: LABOR & DELIVERY

G1. Was your child a product of a multiple birth pregnancy? ☐No ☐Yes
If "No", skip to G2.

If "Yes", was the multiple birth: ☐Twins ☐Other Multiple

If "Twins", what type: ☐Identical ☐Fraternal ☐Unsure

G2. Was Pitocin used to induce or augment this labor? ☐No ☐Yes ☐Unsure

G3. Any labor or delivery complications? ☐No ☐Yes ☐Unsure

If "Yes", describe: ____

____

____

G4. How much did your child weigh at birth? ___ ___ lbs ___ ___ oz OR ___ . ___ kg
Enter in pounds and ounces OR kilograms

G5. Was your child admitted to the NICU (neonatal intensive care unit)? ☐No ☐Yes ☐Unsure
If "Yes":

G5a. For what reason?____

G5b. How old was your child when discharged from the NICU: ____ ____ ____days

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Section H: NEWBORN PROBLEMS AND DEVELOPMENT

*Instructions: Answer section H-M questions with respect to **the child.***

H1. Was your child initially breast or bottle fed? ☐Bottle ☐Breast ☐Both

H2. If breastfed did your child have any feeding difficulty during his/her first month of life (e.g., difficulty latching on)? ☐No ☐Yes ☐Unsure

Section I: DEVELOPMENT HISTORY

Please specify if your child has accomplished any of the following (If "Yes", please provide your best estimate of the age achieved. If unsure of age, write "unsure"):

	a. Achieved? No	a. Achieved? Yes	b. If "Yes" age achieved:
I1. Sit (without support when placed):	☐	☐	___ ___ ___ months
I2. Walk (without holding on):	☐	☐	___ ___ ___ months
I3. First words (other than mama/dada):	☐	☐	___ ___ ___ months
I4. First phrases (2-3 words):	☐	☐	___ ___ ___ months
I5. Toilet training: day, bladder:	☐	☐	___ ___ ___ months
I6. Toilet training: day, bowel:	☐	☐	___ ___ ___ months
I7. Toilet training: night, bladder:	☐	☐	___ ___ ___ months

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Section J: PAST MEDICAL HISTORY/HEALTH CONDITION

Directions: For each condition or symptom listed below, please **check** the extent to which it has been a health problem for your child.

		No Problem	**Mild Problem** (infrequent / resolved)	**Moderate Problem** (recurrent / affects life)	**Severe Problem** (frequent / impacts quality of life)
J1.	Head or skull abnormalities				
	J1a. Large head	☐	☐	☐	☐
	J1b. Misshapen	☐	☐	☐	☐
	J1c. Open soft spot	☐	☐	☐	☐
	J1d. Other, specify: ____________	☐	☐	☐	☐
J2.	Headaches	☐	☐	☐	☐
J3.	Eye conditions				
	J3a. Near sighted	☐	☐	☐	☐
	J3b. Far sighted	☐	☐	☐	☐
	J3c. Lazy eye	☐	☐	☐	☐
	J3d. Other, specify: ____________	☐	☐	☐	☐
J4.	Ear conditions				
	J4a. Infections	☐	☐	☐	☐
	J4b. Hearing	☐	☐	☐	☐
	J4c. Other, specify: ____________	☐	☐	☐	☐
J5.	Nose problems				
	J5a. Sinus infections	☐	☐	☐	☐
	J5b. Blockage	☐	☐	☐	☐
	J5c. Other, specify: ____________	☐	☐	☐	☐
J6.	Lip or Throat problems				
	J6a. Infections	☐	☐	☐	☐
	J6b. Large tonsils	☐	☐	☐	☐
	J6c. Cleft lip or palette	☐	☐	☐	☐
	J6d. Other, specify: ____________	☐	☐	☐	☐
J7.	Dental problems				
	J7a. Cavities	☐	☐	☐	☐
	J7b. Enamel	☐	☐	☐	☐
	J7c. Routine checkups	☐	☐	☐	☐
	J7d. Other, specify: ____________	☐	☐	☐	☐

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	No Problem	Mild Problem (infrequent / resolved)	Moderate Problem (recurrent / affects life)	Severe Problem (frequent / impacts quality of life)
J8. Heart conditions				
J8a. Murmur	☐	☐	☐	☐
J8b. Hole in heart or structural problem	☐	☐	☐	☐
J8c. Rapid rate	☐	☐	☐	☐
J8d. Other, specify: ____________	☐	☐	☐	☐
J9. Lung conditions				
J9a. Asthma	☐	☐	☐	☐
J9b. Pneumonia	☐	☐	☐	☐
J9c. Bronchitis	☐	☐	☐	☐
J9d. Other, specify: ____________	☐	☐	☐	☐
J10. Breast enlargement or milk discharge	☐	☐	☐	☐
J11. Stomach problems				
J11a. Vomiting	☐	☐	☐	☐
J11b. Reflux	☐	☐	☐	☐
J11c. Diarrhea	☐	☐	☐	☐
J11d. Constipation	☐	☐	☐	☐
J11e. Pain	☐	☐	☐	☐
J11f. Other, specify: ____________	☐	☐	☐	☐
J12. Kidney, bladder or urine problems				
J12a. Infections	☐	☐	☐	☐
J12b. Stones	☐	☐	☐	☐
J12c. Urine reflux	☐	☐	☐	☐
J12d. Day or nighttime wetting	☐	☐	☐	☐
J12e. Other, specify: ____________	☐	☐	☐	☐
J13. Genital problems				
J13a. Hernia	☐	☐	☐	☐
J13b. Undescended testicle	☐	☐	☐	☐
J13c. Other, specify: ____________	☐	☐	☐	☐
J14. Bone or joint problems				
J14a. Spine curvature	☐	☐	☐	☐
J14b. Arthritis	☐	☐	☐	☐
J14c. Osteoporosis	☐	☐	☐	☐
J14d. Club foot	☐	☐	☐	☐
J14e. Other, specify: ____________	☐	☐	☐	☐

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	No Problem	Mild Problem (infrequent / resolved)	Moderate Problem (recurrent / affects life)	Severe Problem (frequent / impacts quality of life)
J15. Skin conditions				
J15a. Eczema	☐	☐	☐	☐
J15b. Psoriasis	☐	☐	☐	☐
J15c. Moles	☐	☐	☐	☐
J15d. Café au lait	☐	☐	☐	☐
J15e. Rash	☐	☐	☐	☐
J15f. Acne	☐	☐	☐	☐
J15g. Other, specify: ________	☐	☐	☐	☐
J16. Endocrine or hormone problems				
J16a. Diabetes	☐	☐	☐	☐
J16b. Thyroid	☐	☐	☐	☐
J16c. Early or late puberty	☐	☐	☐	☐
J16d. Menstrual problems	☐	☐	☐	☐
J16e. Other, specify: ________	☐	☐	☐	☐
J17. Growth problem				
J17a. Short stature	☐	☐	☐	☐
J17b. Growth hormone	☐	☐	☐	☐
J17c. Over or under weight	☐	☐	☐	☐
J17d. Other, specify: ________	☐	☐	☐	☐
J18. Tics or movement disorders				
J18a. Tourettes	☐	☐	☐	☐
J18b. Eye blinking	☐	☐	☐	☐
J18c. Shrugging	☐	☐	☐	☐
J18d. Head movements	☐	☐	☐	☐
J18e. Tongue movements	☐	☐	☐	☐
J18f. Hand wringing	☐	☐	☐	☐
J18g. Coordination or gait problems	☐	☐	☐	☐
J18h. Other, specify: ________	☐	☐	☐	☐
J19. Allergies:				
J19a. Foods, specify: ________	☐	☐	☐	☐
J19b. Medications, specify: ________	☐	☐	☐	☐
J19c. Environmental, specify: ________	☐	☐	☐	☐

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	No Problem	Mild Problem (infrequent / resolved)	Moderate Problem (recurrent / affects life)	Severe Problem (frequent / impacts quality of life)
J20. Loss of previously acquired skill				
J20a. Language, specify: ______	☐	☐	☐	☐
J20b. Motor, specify: ______	☐	☐	☐	☐
J20c. Academic, specify: ______	☐	☐	☐	☐
J21. Seizures				
J21a. Staring spells	☐	☐	☐	☐
J21b. Rhythmic jerking	☐	☐	☐	☐
J21c. Febrile seizures	☐	☐	☐	☐
J21d. Other diagnosed seizures	☐	☐	☐	☐
J21e. Other, specify: ______	☐	☐	☐	☐
J22. Previously diagnosed psychiatric illness				
J22a. Anxiety	☐	☐	☐	☐
J22b. Depression	☐	☐	☐	☐
J22c. Manic	☐	☐	☐	☐
J22d. Obsessive / compulsive	☐	☐	☐	☐
J22e. ADHD	☐	☐	☐	☐
J22f. Schizophrenia	☐	☐	☐	☐
J22g. Other, specify: ______	☐	☐	☐	☐
J23. Eating or craving non food items Specify item(s): ______	☐	☐	☐	☐

J24. Was your child born with any birth defects not noted above?	No ☐	Yes ☐	Unsure ☐
J24a. If "Yes", specify: ______			
J25. Has your child ever had a hearing test by an audiologist?	No ☐	Yes ☐	Unsure ☐
J25a. If "Yes", what were the results of the most recent test?	Normal ☐	Abnormal ☐	Unsure ☐
J26. Has your child ever had a brain stem test (ABR) done for hearing?	No ☐	Yes ☐	Unsure ☐
J26a. If "Yes", what were the results of the most recent test?	Normal ☐	Abnormal ☐	Unsure ☐

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ATN ID: _ _ _ _ _ _

Please indicate whether your child has ever been diagnosed with or suspected of having any of the following genetic conditions:

		Never Diagnosed	Suspected Of Having	Diagnosed	Unsure
J27.	Tuberous sclerosis (TS)	☐	☐	☐	☐
J28.	Down syndrome	☐	☐	☐	☐
J29.	Rett syndrome	☐	☐	☐	☐
J30.	Fragile X	☐	☐	☐	☐
J31.	Neurofibromatosis	☐	☐	☐	☐
J32.	Other Genetic Condition	☐	☐	☐	☐

If "Other", specify: ______________________________

Please indicate whether your child has ever been diagnosed with or suspected of having any of the following psychiatric disorders:

		Never Diagnosed	Suspected Of Having	Diagnosed	Unsure
J33.	Depression	☐	☐	☐	☐
J34.	Bipolar Mood Disorder	☐	☐	☐	☐
J35.	Anxiety Disorder	☐	☐	☐	☐
J36.	Obsessive Compulsive Disorder (OCD)	☐	☐	☐	☐
J37.	Attention Deficit Hyperactivity Disorder (ADHD)	☐	☐	☐	☐
J38.	Other Psychiatric Disorder:	☐	☐	☐	☐

If other psychiatric disorder, specify: ______________________________

J39. Has your child ever been hospitalized? ☐No ☐Yes ☐Unsure

J39a. Record from most recent hospitalization backwards. If your child has been hospitalized more than 3 times, 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: ______________

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Section K: IMMUNIZATION RECORD

REMINDER: *Please bring a copy of your child's immunization record to the appointment to review this information with a staff member.*

K1. Is the child up to date on immunizations? ☐No ☐Yes ☐Unsure

Section L: FAMILY HISTORY

Instructions: The questions below ask about the family history of the child.

Please indicate if there is a family history of the disorder. If "Yes", indicate which family member(s). Include only biological (blood) relatives.

	Disorder	No	Yes	Unsure	If "Yes", specify all as related to the child	
L1.	Autistic Disorder (not including Asperger's disorder or Pervasive Developmental Disorder, not otherwise specified):	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L2.	Asperger's Disorder:	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L3.	Pervasive Developmental Disorder, not otherwise specified (PDD-NOS):	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L4.	Rett Syndrome:	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L5.	Mental Retardation:	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other

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	Disorder	No	Yes	Unsure	If "Yes", specify all as related to <u>the child</u>	
L6.	Speech language disorder, received speech therapy:	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L7.	ADHD:	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L8.	Anxiety Disorder or Obsessive-Compulsive Disorder:	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L9.	Depression:	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L10.	Manic depression or bipolar disorder:	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L11.	Schizophrenia:	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L12.	Seizures:	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L13.	Neurofibromatosis:	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other

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	Disorder	No	Yes	Unsure	If "Yes", specify all as related to <u>the child</u>	
L14.	Fragile X:	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L15.	Tuberous Sclerosis:	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L16.	Auto-immune disorders (e.g., Lupus, Rheumatoid Arthritis, Multiple Sclerosis):	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L17.	Inflammatory Bowel Disease (Crohn's or Ulcertative Colitis), etc.):	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other
L18.	Other condition that is in 2 or more generations:	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Other

If "Yes", specify condition: ______________________________

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Section M: LABS, IMAGING, EEG

Please indicate whether your child has ever had any of the following procedures:

M1.	Karyotype	☐No	☐Yes	☐Unsure
M2.	Fragile X DNA	☐No	☐Yes	☐Unsure
M3.	CGH Microarray	☐No	☐Yes	☐Unsure
M4.	Testing for Rett Syndrome (MECP2)	☐No	☐Yes	☐Unsure
M5.	Plasma Amino Acids	☐No	☐Yes	☐Unsure
M6.	Urine for Organic Acids	☐No	☐Yes	☐Unsure
M7.	Uric Acid	☐No	☐Yes	☐Unsure
M8.	MRI of the brain	☐No	☐Yes	☐Unsure
M9.	EEG	☐No	☐Yes	☐Unsure
M10.	Sleep Study	☐No	☐Yes	☐Unsure
M11.	Lead screening	☐No	☐Yes	☐Unsure

Examiner Initials: ___ ___ ___

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

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ATN ID: __ __ __ __ __ __

Staff Reviewer: ____________________ *Date of Review: ___/___/___*