

Diagnostic Questionnaire for Parent/Guardian of Adult Client (age 18 and over)

Adult Client Name: _____ Date of Birth: _____

Form completed by: _____ Date: _____

Parent/Guardian 1 Name: _____

Parent/Guardian 2 Name: _____

Is client his/her own guardian (for adult clients only)? **Yes** **No**

In North Carolina, all persons over 18 years of age who have not had their rights to manage their money and medical care legally transferred to someone else by a judge are their own guardians.

**Client must sign a release of information form before we can contact non-guardian parents*

EDUCATIONAL HISTORY

Learning Problems - Check any of the following that applied to your son/daughter at any time during his/her schooling

| | | |
|--|-----|----|
| Was placed in Special Education classes | Yes | No |
| Was placed in classes for gifted children | Yes | No |
| Had special testing at school or at a clinic | Yes | No |
| Received special help (<i>tutoring, special assignments, extra time completing work</i>) | Yes | No |
| Had problems taking tests | Yes | No |
| Was an early reader (<i>started reading before first grade</i>) | Yes | No |
| Was disciplined for serious behavior difficulties | Yes | No |
| Had an individualized education plan (IEP) | Yes | No |
| Had a 504 Plan | Yes | No |

What was your son/daughter's:

Best subject(s)? _____

Worst subject(s)? _____

Favorite subject(s)? _____

Least favorite subject(s)? _____

What (if any) extracurricular activities did your son/daughter participate in *(sports, band, boy/girl scouts)?*

How was your son/daughter at finishing homework and class work? *Check any that apply.*

Needed lots of reminders

Always finished on time

Put it off until the last minute

Refused to do it

Never remembered his/her assignments

Other: _____

Did any of your son/daughter's teachers express any concerns about your son/daughter *(about how he/she was doing in school, or concern about behavior or how he/she was getting along with other children)?*

BEHAVIORAL HISTORY

As you answer the following questions, try to think of your son/daughter's behaviors and interactions before he/she started elementary school.

SOCIAL INTERACTIONS *(before elementary school):*

How did your son/daughter interact with people in the following categories:

Family members: Did he/she enjoy affection, seek attention, play baby games such as peek-a-boo, play alone in the play pen, ask to visit or contact family members, etc.?

Other Children: Did he/she have a lot of friends, play in groups, have a best friend, ask other children to play, watch other children play, avoid other children, prefer adults to children?

Groups of people: How did your son/daughter handle groups such as birthday parties, church, preschool, the park?

COMMUNICATION (*before elementary school*):

Was there anything unusual about the way your son/daughter communicated? *Please give an example.*

What were your son/daughter's favorite things to talk about?

Did your son/daughter look at people when he/she talked? **Yes** **No**

Did your son/daughter repeat or memorize things that he/she had heard? **Yes** **No**

Did your son/daughter show you things that he/she liked or tell you about things that happened when you weren't there (*e.g. telling you what happened when he/she was out playing*)? **Yes** **No**

Did your son/daughter point to things to draw your attention to them (*e.g. pointing to a car or dog that he/she had noticed*)? **Yes** **No**

ROUTINES (*before elementary school*):

Was there anything unusual about the way your son/daughter talked or the way his/her voice sounded (*e.g. too quiet or loud, mechanical, high pitched, etc.*)? **Yes** **No**

Did your son/daughter have to do things in a certain way (*take the same route to the store, eat food on a certain dish, dress in a certain way*)? Please give an example.

How did your son/daughter respond to unexpected change in his/her routine?

How did your son/daughter respond to changes in his/her environment (*moving furniture, moving to a new home, changes in the season*)?

How did your son/daughter respond to new places or new people?

PLAY (*before elementary school*):

What were your son/daughter's favorite toys and did he/she play appropriately with them? Was his/her play in any way unusual? Please describe.

Was there any toy that your son/daughter had to keep with him/her most of the time? Please describe.

Did your son/daughter play with things other than toys? Please describe.

Did your son/daughter play pretend games (*alone: such as dolls, action figures, cars and/or with other children: such as playing teacher, cowboys, etc.*)? Please describe.

PARENT OF ADULT CLIENT ESTIMATE

As a part of our initial diagnostic evaluation, we ask you to make some estimates about your son/daughter's current functioning. Please use your best understanding of your son/daughter's skill levels and difficulties in order to make these estimates of his/her current functioning.

Please write your estimate of the age level at which you believe your son/daughter is currently functioning in the following.

Ability to Communicate - Refers to sound imitation, babbling, following directions, talking or understanding what is said, having a conversation, etc.

age: _____

Fine & Gross Motor Development - Refers to use of large muscles, moving about, coordination and balance (walking, throwing, catching a ball), as well as the use of small muscles (manipulating small objects, handwriting).

age: _____

Social Development - Refers to enjoying being talked to and held, getting along with others, playing cooperatively and participating in a group activity.

age: _____

Daily Living Skills - Refers to such things as eating and drinking, dressing, zipping/buttoning, brushing hair, toileting, drying hands, etc.

age: _____

Cognitive Development - Refers to problem solving ability, ability to learn new skills, general knowledge.

age: _____

Overall Ability - Refers to all skills.

age: _____

Please review diagnostic categories listed below and check all those that you think apply to your son/daughter. Also, rate the degree to which you think this problem interferes with your son/daughter's development.

| | Diagnostic Category | | | Degree of Interference | | |
|--|---------------------|----------------|-------------|------------------------|----------|--------|
| | Appropriate | Does not apply | Do not know | Mild | Moderate | Severe |
| Autism/ASD | | | | | | |
| Asperger Disorder | | | | | | |
| Pervasive Developmental Disorder (PDD-NOS) | | | | | | |
| Intellectual Disability <i>(formerly know as Mental Retardation)</i> | | | | | | |
| Language Impairment | | | | | | |
| Attention Deficit Hyperactivity Disorder (ADHD) | | | | | | |
| Learning Disability | | | | | | |
| Emotional Disorder | | | | | | |
| Rett Syndrome | | | | | | |
| Schizophrenia | | | | | | |
| Other (specify): | | | | | | |

Person completing this questionnaire: _____

Relationship to client: _____ Date: _____

Please mail this completed form to the local TEACCH Center