Diagnostic Questionnaire for Parent/Guardian of Child or Adolescent

Child's Name: _____ Date Completed: _____

Age: _____ Date of Birth: _____

Parent Name: _____ Relationship to child: _____

Each parent/guardian should complete a separate questionnaire for the child. Use additional pages if needed.

1) Describe a typical day of your experience with your child *(feel free to include your thoughts, feelings and actions with your child, as well as his/her behavior and feelings).*

2) What are your main concerns at present for your child?

3) What is most satisfying and gratifying to you about your child?

4) What effect has your child had on other aspects of your life *(marriage, family relations, social relations, work situations, and so forth)**?***

5) What do you expect from your participation in the TEACCH Autism Program?

PARENT 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)	☐	☐	☐		☐	☐	☐
Intellectual Disability *(formerly known as Mental Retardation)*	☐	☐	☐		☐	☐	☐
Language Impairment	☐	☐	☐		☐	☐	☐
Attention Deficit Disorder/Hyperactivity	☐	☐	☐		☐	☐	☐
Learning Disability	☐	☐	☐		☐	☐	☐
Emotional Disorder	☐	☐	☐		☐	☐	☐
Rett Syndrome	☐	☐	☐		☐	☐	☐
Schizophrenia	☐	☐	☐		☐	☐	☐
Other (specify):	☐	☐	☐		☐	☐	☐

Please send completed forms to the local TEACCH Center