MICHIGAN STATE
UNIVERSITY

APPROVED AUTISM EVALUATION CENTER FOR CHILDREN AND ADOLESCENTS

Thank you for your interest in Michigan State University's ***Approved Autism Evaluation Center for Children and Adolescents***, a service of the Department of Psychiatry and the MSU HealthTeam.

The enclosed packet of material needs to be completed and returned to our office before an appointment can be scheduled.

Obtaining as much information as possible regarding your child will assist us in performing an accurate and thorough assessment. Please complete the enclosed forms as accurately and completely as possible, and return them in the enclosed envelope.

Once our office receives the completed forms you will be contacted by two separate offices to schedule two separate appointments.

Your child's first appointment will be with a MSU Pediatrician. At the second appointment your child will see a MSU Psychiatrist and a Speech and Language Therapist.

Please note that your child will be seen for the purpose of assessment and treatment recommendations only.

Thank you for your prompt consideration. If you have any questions, please feel free to contact us at (517) 353-3070.

Enclosures

Michigan State University

DEPARTMENT OF PSYCHIATRY

West Fee Hall
909 Fee Road
East Lansing, MI 48824-1315

517-353-3070
Fax: 517-432-3603
www.psychiatry.msu.edu

MSU Health Care

Patient Registration

Last Name: _____ First Name: _____

First Name Used: _____ DOB: _____ SSN: _____

Legal Sex: _____ Assigned at birth: _____ Gender Identity: _____

Preferred Pronoun: ☐ he/him ☐ she/her ☐ they/them

Sexual Orientation: ☐ Lesbian or gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Secondary Number: _____

Email (Not parent email if minor): _____

Language Preference: _____

Race: _____ Ethnicity: _____

Marital Status: _____

PRIMARY INSURANCE

Holder: _____

Group #: _____

Policy: _____

SECONDARY INSURANCE

Holder: _____

Group #: _____

Policy: _____

EMERGENCY CONTACT

Name: _____

Relation: _____

Phone Number: _____

Secondary Number: _____

NEXT OF KIN

Name: _____

Relation: _____

Phone Number: _____

PARENT/GUARDIAN(S)

Parent/Guardian #1 Name: _____

Phone: _____ Email: _____

Street Address (if different than patient): _____

City: _____ State: _____ Zip: _____

Parent/Guardian #2 Name: _____

Phone: _____ Email: _____

Street Address (if different than patient): _____

City: _____ State: _____ Zip: _____

Office Use Only	MRN	NP __ PASCA __	BP	Wt	Ht

Michigan State University Department of Psychiatry
Comprehensive Autism Spectrum Evaluation Center

Department of Psychiatry
Michigan State University
West Fee Hall
909 Fee Road Room B120
East Lansing, MI 48824

Department of Pediatrics, College of Osteopathic Medicine
Michigan State University
Central Fee Hall
939 Fee Rd, E109
East Lansing, MI 48824

Comprehensive Speech and Therapy Center, Inc.
1001 Laurence Ave, Ste B
Jackson, MI 49202
Ph. (517) 750-4777

Please help us become acquainted with your child & family by the answering the following questions as thoroughly as possible.

Child's Name __ Male __ Female	Child's Date of Birth	Age	School	Grade

Your Name	Home Address	Child's Pediatrician or Family Doctor
Relationship to Child		Doctor's Address & Phone Number
Telephone __ Home __ Cell		

How did you hear of our clinic? __ Pediatrician/Family Doctor __ Therapist __ School __ Insurance __Other: _____
Language Spoken at home? _____

BACKGROUND INFORMATION

Chief Complaint? Please provide a brief description of your concerns and/or the reason for your visit.

Does your child or has your child difficulty with any of the following? Check all that apply.

__ Sleep problems	__ Inflated self confidence	__ Frequent physical complaints	__ Bizarre ideas or experiences
__ Eating problems	__ Episodic increases in energy	__ Attention/concentration	__ Hallucinations
__ Sadness/crying	__ Excessive worries or fears	__ Repetitive movements or sounds	__ Special idiosyncracies
__ Anger/irritability	__ Nervous habits	__ Defiance	__ Sensory issues
__ Tantrums/rages	__ Repetitive thoughts or actions	__ School avoidance or truancy	__ Delays in development
__ Feeling hopeless/guilty	__ Panic attacks	__ Bullying others or being bullied	__ Bedwetting or toileting issues
__ Unable to enjoy activities	__ History of traumatic event(s)	__ Tobacco, alcohol or drug use	__ Nightmares
__ Harm to self	__ Problems with friends	__ Lying or theft	__ Snoring
__ Harm to others or property	__ Problems in classroom	__ Excess concerns about weight	__ Speech problems

Sleep related issues — **No Problem**

Difficulty Falling Asleep: _____ __
fall asleep alone: _____ __
Awakening at night: _____ __
Sleep walking, talking, night terrors: _____ __
Snoring or breathing difficulty: _____ __
Change in amount of sleep needed per night: _____ __
Daytime sleepiness: _____ __

Has your child ever been prescribed medications for this problem or mental health reasons? __Yes __No If yes, please complete the following:

Name of Medication	Dates Taken	Prescribed by	Reason	Outcome

Has your child been seen by a counselor/therapist in the past? __ Yes __ No If yes, please complete the following:

Name	Dates Seen	Reason Seen	Type of Therapy

Has your child been seen by a psychiatrist in the past? __ Yes __ No If yes, please complete the following:

Name	Dates Seen	Reasons and/or Diagnoses?

Has your child ever been psychiatrically hospitalized? __ Yes __ No If yes, please complete the following:

Name	Dates	Reasons and/or Diagnoses?

Does your child drink caffeine (tea, pop, coffee, energy drinks, etc)? __ Yes __ No If so, how much? _____

Do you have any concerns about your child using drugs and/or alcohol? __ Yes __ No

If yes, please explain: _____

Do you have guns or other weapons in your home? __ Yes __ No

THERAPY HISTORY:

Litst any therapy your child has received (when, where, and duration of treatment):

_____

Is there any other important information that you feel may be helpful to your child's treatment?

_____

What goals would you like your child to achieve through therapy?

_____

This information will be kept confidential and used solely for the purpose of providing the appropriate care to the client. Thank you.

MEDICAL HISTORY

When was child last seen by their doctor? _____ Reason? _____

Does your child have any health problems? __ Yes __ No If yes, please list:

Does your child have any chronic medical conditions? __ Yes __ No If yes, please list:

Please circle if your child has had the following:

Chicken Pox Measles Mumps Rheumatic Fever
Scarlet Fever Whooping Cough Roseola Polio
Meningitis Encephalitis Tuberculosis

Has your child ever experienced any of the following? __ Yes __ No

** If yes to any, please describe below:

Hospitalization? __ Yes __ No
Any accidents? __ Yes __ No
Surgery? __ Yes __ No
Any head injuries? __ Yes __ No
Heart problems? __ Yes __ No
Had a seizure(s)? __ Yes __ No

Is child allergic to any medication(s)? __ Yes __ No If yes, please list: _____

Does child take any prescribed medication(s)? __ Yes __ No If yes, please list:

Vaccinations up to date? __ Yes __ No __ Don't Know

Medication	Dose	How often	Reason

Does child take vitamins, minerals or other non-prescription medications? __ Yes __ No Is so, list:

Name	How often	Reason

DEVELOPMENTAL HISTORY

Pregnancy

Normal pregnancy? __ Yes __ No

If problems, please describe: _____

During pregnancy, did mother use any of the following? If yes, provide details regarding use, timing, amount, etc..

Medications? __ Yes __ No _____ Alcohol? __ Yes __ No _____

Tobacco? __ Yes __ No _____ Illicit drugs? __ Yes __ No _____

Labor & Delivery

Full Term? __ Yes __ No If no? __ Premature __ Overdue By how many weeks? _____

Labor __ Easy __ Difficult How many hours?_____ Baby's presentation? __ head first __ breech

Delivery? Vaginal __ C-section __ Induced? __ Yes __ No Birth Weight _____ lbs _____ oz

If C-section, why? _____

Following delivery, did your child...

Need supplemental oxygen? __ Yes __ No
Need blood transfusion? __ Yes __ No
Need X-rays, CT or MRI? __ Yes __ No
Show signs of birth trauma? __ Yes __ No
Have other complications? __ Yes __ No

Newborn Period

Did child exhibit the following? How long?

__ Yes __ No Irritability _____
__ Yes __ No Vomiting _____
__ Yes __ No Convulsions/Seizures _____
__ Yes __ No Difficulty Breathing How long? _____
__ Yes __ No Breastfeeding _____
__ Yes __ No Normal weight gain _____

Develop-ment

Any concerns your child was delayed in development? __ Yes __ No If yes, circle area(s) of concern: Motor / Language / Social

	Age		Age		Age
Sitting without help		Spoke single words		Weaned	
Crawling		Spoke in sentences		Bladder Trained	
Walking		Puberty		Bowel Trained	

Speech/Language milestones: At what age did your child:

Babble: _____ First word: _____ Combine two words: _____ Use sentences: _____

Does your child speak clearly? __ Yes __ No Do others understand your child? __ Yes __ No

Is your child's voice hoarse or husky? __ Yes __ No Describe _____

Does your child stutter? __ Yes __ No Describe _____

Is your child self conscious about his/her speech? __ Yes __ No Describe _____

In relationships to siblings and peers?

__ Plays individually __ Competitive __ Leader
__ Plays in groups __ Cooperative __ Follower

Education

Types of Classes:

__ Regular Education __ Resource Room __ Alternative Education __ Home Schooling
__ Special Education __ Learning Disabled __ Emotionally Impaired __ 504 plan
__ Other - Please describe any additional interventions including school accommodations, tutoring, etc:

_____

Has your child had specific learning difficulties? __ Yes __ No Has your child undergone testing to evaluate? __ Yes __ No
If yes, please describe in detail below and bring copy of any testing results to your visit:

_____

Has your child ever skipped a grade? __ Yes __ No Repeated a grade? __ Yes __ No If yes to either, please describe:

_____

Name / title / phone number of person at school familiar with your child's behavior and academic performance.

_____

	Name of School	City	Date Began	Date Ended	Grades completed at this school
Preschool					
Elementary					
Middle School					
High School					

Please complete the following for current family situation. Additional lines available for stepparents, guardians, etc.

Relation	Name	Age	DOB	Birthplace	Education	Occupation	Religion
Mother							
Father							

Parents: __ Married __ Separated __ Divorced If remarried or previously married, please provide dates:

Dates _____ _____ _____ Mother Father _____

If parents not together, what is custody agreement? _____

__ Deceased M / F Date/Circumstances _____

Siblings – Please complete the following for all siblings.

Name	Age	Sex	School or Occupation	Grade	Relationship (full, half, step, etc.)	Living at Home	Any Mental Illness?	Uses drugs or alcohol?
		__M __F				__Y __N	__Y __N	__Y __N
		__M __F				__Y __N	__Y __N	__Y __N
		__M __F				__Y __N	__Y __N	__Y __N
		__M __F				__Y __N	__Y __N	__Y __N
		__M __F				__Y __N	__Y __N	__Y __N
		__M __F				__Y __N	__Y __N	__Y __N

Sources of family income? _____

Sources of family stress? _____

Living Arrangements – Please list all individuals residing in the home & their relationship to child?

_____ _____

_____ _____

_____ _____

_____ _____

Number of moves _____

Location	Dates	House / Apt / Other	Rent / Own
	to		
	to		
	to		
	to		

Has child ever lived away from family? __ Yes __ No If yes, explain: _____

If child is adopted?

Adoption Source _____ Age of child when first in home _____ Date of legal adoption _____

Reason/circumstance _____

What has child been told? _____

Describe your child's interactions with adults: _____

_____

Describe your child's interactions with other children: _____

_____

Whom does your child count on when upset? _____

_____

How would you describe your child's personality and/or temperament?

__ Active __ Easy __ Quiet
__ Difficult __ Fussy __ Slow to warm up
__ Easily Upset __ Happy go lucky __ Other:

What words best describe the child?

__ Friendly __ Withdrawn __ Few friends
__ Popular __ Socially awkward __ No friends
__ Leader __ Shy - interested in friends __ Not interested in friends
__ Used to have more friends

LEGAL HISTORY

Has your child ever been:

In trouble with the police? __ Yes __ No
Arrested? __ Yes __ No
On probation? __ Yes __ No
Charged with a crime? __ Yes __ No
Convicted of a crime? __ Yes __ No
In juvenile detention or jail? __ Yes __ No

If yes to any of the above, describe: _____

FAMILY HISTORY

Any family history of cardiovascular disease before age 35 including arrhythmia, fainting, sudden death, etc? __ Yes __ No

Please indicate any mental health history in each of the child's biological or blood relatives with an X in the corresponding column.

	Siblings	Father	Paternal (father's) Family			Mother	Maternal (mother's) Family		
			Aunts / Uncles	Grand parents	Cousins / Other		Aunts / Uncles	Grand parents	Cousins / Other
Depression									
Anxiety									
Obsessions or Compulsions									
Mania or Bipolar Disorder									
Psychosis or Schizophrenia									
Attention or Concentration Problems									
Hyperactivity Problems									
Learning Problems									
Mental Retardation									
Alcohol Problems									
Drug Use Problems									
Legal Problems									
Abuse or Neglect									
History of suicide attempts									
History of harming self									
History of harming others									
History of psychiatric hospitalization									
Use of psychiatric medication									

REVIEW OF SYSTEMS: Please check box marked YES if your child has experienced any of the following. If not, leave blank.

YES GENERAL
- ☐ Fevers/chills?
- ☐ Weight loss?
- ☐ Changes to energy level?

YES HEENT
- ☐ Glasses?
- ☐ Hearing problems?
- ☐ Ear infections and/or ear pain?
- ☐ Seasonal/environmental allergies?
- ☐ Strep throat?
- ☐ Sinus problems?

YES NEURO
- ☐ Vision changes or problems?
- ☐ Head injury?
- ☐ Trouble walking?
- ☐ Seizures?
- ☐ Headaches?
- ☐ Numbness/tingling?
- ☐ Clumsiness/balance problems?

YES CV
- ☐ Chest pain?
- ☐ Fainting?
- ☐ Feeling heart beating or racing?
- ☐ Problems with blood pressure?
- ☐ Heart murmur?

YES PULM
- ☐ Wheezing or asthma?
- ☐ Trouble breathing at rest?

YES ENDO
- ☐ Intolerance to heat or cold?
- ☐ Unusual weight changes?
- ☐ Problems with blood sugar?
- ☐ History of diabetes?

YES HEME
- ☐ Bleeding problems?
- ☐ Abnormal bruising?

YES GI
- ☐ Frequent stomachaches?
- ☐ Nausea and/or vomiting?
- ☐ Diarrhea?
- ☐ Constipation?

YES GU
- ☐ Problems urinating?
- ☐ Bladder or kidney infections?
- ☐ Nighttime incontinence?

YES MSK
- ☐ Joint pains or swelling?
- ☐ Growing pains?
- ☐ Muscle weakness?

YES SKIN
- ☐ Rashes?
- ☐ Picking?
- ☐ Large or unusual birthmarks?

CHILD AND ADOLESCENT PSYCHIATRY

ABC CHECKLIST

Child:_____ Rater:_____ Date:_____

INSTRUCTIONS: The rater should be familiar with the child's everyday behavior. Please rate behaviors and avoid interpretations of motives; please rate very item including those about which you are uncertain. Please make additional comments as you see fit.

Rating Weights:

0 – Rarely or never or disagree
1 – Sometimes (2/3 times per week) or some agreement
2 – Very often (daily) or strongly agree
P – Past behavior, not seen at this time
N/A – Not applicable

_____ 1. Whirls self for long periods of time.

_____ 2. Learns a simple task for "forgets" quickly.

_____ 3. Child frequently does not attend to social/environmental stimuli.

_____ 4. Doesn't follow simple commands when given once (e.g., sit down, come here).

_____ 5. Does not use toys appropriately (e.g., spins tires, turns over in hands).

_____ 6. Poor use of visual discrimination when learning (fixates on one characteristic such as size, color or position.

_____ 7. Has no social smile.

_____ 8. Has pronoun reversal (you for I, etc).

_____ 9. Insists on keeping certain objects with him/her.

_____ 10. Seems not to hear, so that a hearing loss is suspected.

_____ 11. Speech is atonal and arrhythmic (e.g., monotone, mechanical, stereotyped, inappropriate voice quality, etc).

_____ 12. Rocks self for long periods of time.

_____ 13. Does not (or did not as a baby) reach out when reached for.

_____ 14. Strong reactions to changes in routine/environment.

_____ 15. No response to own name when called out with two others (Joe, Bill, Mary).

_____ 16. Does a lot of lunging and darting about, interrupting with spinning, toe walking, flapping, etc.

_____ 17. Not responsive to other people's facial expressions/feelings.

_____ 18. Seldom uses "yes" or "I."

_____ 19. Has "social abilities" in one area of development, which seems to rule out mental retardation. Evidences early or unusual interest in numbers, music, etc., relative to other skills.

_____ 20. Does not follow simple commands involving prepositions ("put the ball on the box" or "put the ball in the box."

_____ 21. Sometimes shows no "startle response" to a loud noise (may have thought child was deaf).

_____ 22. Flaps hands.

_____ 23. Severe temper tantrums and/or frequent minor tantrums.

_____ 24. Actively avoids eye contact.

_____ 25. Resists being touched or held (past or present).

_____ 26. Sometimes painful stimuli such as bruises, cuts or injections evoke no reaction.

_____ 27. Is (or was as a baby) still and hard to hold.

_____ 28. Is flaccid (doesn't cling) when held in arms.

_____ 29. Gets desired objects by gesturing (points, takes adult's hand to place on object, leads adults to desired object).

_____ 30. Walks on toes.

_____ 31. Hurts others by biting, hitting, kicking, etc.

_____ 32. Repeats phrases over and over.

_____ 33. Does not imitate other children at play.

_____ 34. Often will not blink when a bright light is directed toward eyes.

_____ 35. Hurts self by banging head, biting hand, etc.

_____ 36. Does not wait for needs to be met (wants things immediately).

_____ 37. Cannot point to more than five named objects.

_____ 38. Has not developed any friendships.

_____ 39. Covers ears at many sounds.

_____ 40. Twirls, spins, and bangs objects a lot.

_____ 41. Difficulties with toilet training.

_____ 42. Uses 0-5 spontaneous words per day to communicate wants and needs.

_____ 43. Often frightened or very anxious.

_____ 44. Squints, frowns, or covers eyes in the presence of natural light.

_____ 45. Does not dress without frequent help.

_____ 46. Repeats sounds or words over and over.

_____ 47. Looks "through" people.

_____ 48. Echoes questions or statements made by others.

_____ 49. Frequently unaware of surroundings, and may be oblivious to dangerous situations.

_____ 50. Prefers to manipulate and stays busy with toys or objects.

_____ 51. Will feel, smell and/or taste objects in the environment.

_____ 52. Frequently has no visual reaction to a "new" person.

_____ 53. Gets involved in complicated "rituals" such as lining things up, etc.

_____ 54. Is very destructive (toys and household items are soon broken).

_____ 55. A developmental delay was identified at or before 30 months of age.

_____ 56. Uses at least 15, but less than 30 spontaneous phrases daily to communicate.

_____ 57. Stares into space for long periods of time.

_____ 58. Difficulty in following multiple or complex directions (e.g., get your coat and wait at the door, find the big blue ball, put your books away and take out your crayons).

_____ 59. Problems in using abstract, cause-and-effect, or symbolic thinking (confuses multi-meaning words such as watch, block, cross; doesn't understand idioms or slang such as "it's raining cats and dogs"; confuses identical sounding word pairs such as bear/bare, herd/heard).

_____ 60. Irrelevant or bizarre speech.

_____ 61. Stares at or carefully examines own hands and/or stares through fingers.

_____ 62. Picky eater, shows unusual or limited preferences. Intolerant of some tastes and textures.

_____ 63. Very active physically; paces or runs around the room, always on the go, darts, and/or reckless.

_____ 64. Lacks ability to initiate or role play in "pretend" play situations.

_____ 65. Memory is unusually good relative to age level or other abilities for specific associations, chains of information, events, etc.

_____ 66. Loss of general skills or abilities that had been acquired previously.

_____ 67. Is preoccupied with body functions (e.g., interest in excretions, frequent open masturbation, sores).

_____ 68. Shows fascination with certain objects such as faucets, toilets, light switches, water, bright objects, gum, etc.)

_____ 69. Uneven patterns of skills and abilities in different areas of development (e.g., good coordination and memory, but poor language and play skills).

Cambridge University Behaviour and Personality Questionnaire For Children

NOTE: This questionnaire is to be completed by the parent/guardian of each child aged 4 and above. Please complete all three pages.

Name .....
Date of Birth (Month in words) ..... **Today's date (Month in words)**.....
Address.....

Please answer each of the following questions about your child or the person who is under your care by ticking a box that reflects your answer to the question most appropriately. If there is any question that you feel not able to comment, please ask your son, daughter, partner or the person to answer.

	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
1. S/he prefers to do things with others rather than on her/his own.				
2. S/he prefers to do things the same way over and over again.				
3. If s/he tries to imagine something, s/he finds it very easy to create a picture in her/his mind.				
4. S/he frequently gets so strongly absorbed in one thing that s/he loses sight of other things.				
5. S/he often notices small sounds when others do not.				
6. S/he usually notices house numbers or similar strings of information.				
7. S/he has difficulty understanding rules for polite behaviour.				
8. When s/he is read a story, s/he can easily imagine what the characters might look like.				
9. S/he is fascinated by dates.				
10. In a social group, s/he can easily keep track of several different people's conversations.				
11. S/he finds social situations easy.				
12. S/he tends to notice details that others do not.				
13. S/he would rather go to a library than a birthday party.				

	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
14. S/he finds making up stories easy.				
15. S/he is drawn more strongly to people than to things.				
16. S/he tends to have very strong interests, which s/he gets upset about if s/he can't pursue.				
17. S/he enjoys social chit-chat.				
18. When s/he talks, it isn't always easy for others to get a word in edgeways.				
19. S/he is fascinated by numbers.				
20. When s/he is read a story, s/he finds it difficult to work out the characters' intentions or feelings.				
21. S/he doesn't particularly enjoy fictional stories.				
22. S/he finds it hard to make new friends.				
23. S/he notices patterns in things all the time.				
24. S/he would rather go to the cinema than a museum.				
25. It does not upset him/her if his/her daily routine is disturbed.				
26. S/he doesn't know how to keep a conversation going with her/his peers.				
27. S/he finds it easy to "read between the lines" when someone is talking to her/him.				
28. S/he usually concentrates more on the whole picture, rather than the small details.				
29. S/he is not very good at remembering phone numbers.				
30. S/he doesn't usually notice small changes in a situation, or a person's appearance.				
31. S/he knows how to tell if someone listening to him/her is getting bored.				
32. S/he finds it easy to go back and forth between different activities.				
33. When s/he talk on the phone, s/he is not sure when it's her/his turn to speak.				

	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
34. S/he enjoys doing things spontaneously.				
35. S/he is often the last to understand the point of a joke.				
36. S/he finds it easy to work out what someone is thinking or feeling just by looking at their face.				
37. If there is an interruption, s/he can switch back to what s/he was doing very quickly.				
38. S/he is good at social chit-chat.				
39. People often tell her/him that s/he keeps going on and on about the same thing.				
40. When s/he was in preschool, s/he used to enjoy playing games involving pretending with other children.				
41. S/he likes to collect information about categories of things (e.g. types of car, types of bird, types of train, types of plant, etc.).				
42. S/he finds it difficult to imagine what it would be like to be someone else.				
43. S/he likes to plan any activities s/he participates in carefully.				
44. S/he enjoys social occasions.				
45. S/he finds it difficult to work out people's intentions.				
46. New situations make him/her anxious.				
47. S/he enjoys meeting new people.				
48. S/he is good at taking care not to hurt other people's feelings.				
49. S/he is not very good at remembering people's date of birth.				
50. S/he finds it very to easy to play games with children that involve pretending.				

M-CHAT

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

1.	Does your child enjoy being swung, bounced on your knee, etc.?	Yes No
2.	Does your child take an interest in other children?	Yes No
3.	Does your child like climbing on things, such as up stairs?	Yes No
4.	Does your child enjoy playing peek-a-boo/hide-and-seek?	Yes No
5.	Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?	Yes No
6.	Does your child ever use his/her index finger to point, to ask for something?	Yes No
7.	Does your child ever use his/her index finger to point, to indicate interest in something?	Yes No
8.	Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them?	Yes No
9.	Does your child ever bring objects over to you (parent) to show you something?	Yes No
10.	Does your child look you in the eye for more than a second or two?	Yes No
11.	Does your child ever seem oversensitive to noise? (e.g., plugging ears)	Yes No
12.	Does your child smile in response to your face or your smile?	Yes No
13.	Does your child imitate you? (e.g., you make a face-will your child imitate it?)	Yes No
14.	Does your child respond to his/her name when you call?	Yes No
15.	If you point at a toy across the room, does your child look at it?	Yes No
16.	Does your child walk?	Yes No
17.	Does your child look at things you are looking at?	Yes No
18.	Does your child make unusual finger movements near his/her face?	Yes No
19.	Does your child try to attract your attention to his/her own activity?	Yes No
20.	Have you ever wondered if your child is deaf?	Yes No
21.	Does your child understand what people say?	Yes No
22.	Does your child sometimes stare at nothing or wander with no purpose?	Yes No
23.	Does your child look at your face to check your reaction when faced with something unfamiliar?	Yes No