Developmental History & Parent/Caregiver Interview

Evaluator:	Date Completed:
Name:	Parent/Caregiver #1:
DOB:	Parent/Caregiver #2:
Gender:	Relationship to the child/student:

Section 1: Prenatal and Birth History

During pregnancy, did the mother have any of the following? (check any that apply and list)

☐ Medical conditions (e.g., diabetes, high blood pressure, high fever/flu, infection) (please list):

☐ Used over-the-counter and/or prescription medications (please list):

☐ Drank alcohol Mother used recreational drugs (please list)

☐ Smoked cigarettes

☐ Other serious illnesses or complications during pregnancy? (please list)

Where there any complications during pregnancy with this child? ☐ No ☐Yes ☐ Don't Know
If "yes", please describe:

Was the child born on schedule? ☐ No ☐ Yes ☐ Don't Know
If "no," how many weeks gestation?

Was there anything unusual about the delivery or birth? ☐ No ☐ Yes ☐ Don't Know
If "yes", please describe:

Was the delivery: ☐ Normal ☐ Breech ☐Cesarean ☐ Forceps ☐ Induced ☐ Don't Know

Birth weight: ☐ Don't Know Birth Length: ☐ Don't Know

What were the APGAR Scores? 1 minute: 5 minute: ☐ Don't Know

Did the child have any health problems at birth or during infancy? (check all that apply)
☐ Serious breathing difficulty ☐ Yellow jaundice ☐ I.V. feedings ☐ Seizures or convulsions
☐ Difficulty establishing feeding ☐Cried quickly ☐ Color Abnormal ☐ Appeared Bluish ☐Received Oxygen ☐ Received phototherapy ☐ Birth Defects - Describe:

Other problems following delivery? Please describe:

Section 2: Developmental Milestones

By around **two (2) months** did the child...

- ➢ Smile in response to the parent/caregiver smiling? ☐ Yes ☐ No ☐ Don't Know
- ➢ Start making cooing/vocal sounds? ☐ Yes ☐ No ☐ Don't Know
- ➢ Turn his/her head toward the the sound of someone talking? ☐ Yes ☐ No ☐ Don't Know

By around **nine (9) months** did the child...

- ➢ Respond to their name? ☐ Yes ☐ No ☐ Don't Know
- ➢ Babble ("mama", "dada")? ☐ Yes ☐ No ☐ Don't Know
- ➢ Respond to or play along with "Peek-a-boo" or "Pat-a-cake" ☐ Yes ☐ No ☐ Don't Know

By around **twelve (12) months** did the child...

- ➢ Wave "bye bye"? ☐ Yes ☐ No ☐ Don't Know
- ➢ Point to things they wanted? ☐ Yes ☐ No ☐ Don't Know
- ➢ Use single words other than "mama" or "dada"? ☐ Yes ☐ No ☐ Don't Know

By around **eighteen (18) months** did the child...

- ➢ Look at you and point when he/she wanted to show you something? ☐ Yes ☐ No ☐ Don't Know
- ➢ Brings toys or other items to show them to you? ☐ Yes ☐ No ☐ Don't Know
- ➢ Look when you pointed to something? ☐ Yes ☐ No ☐ Don't Know
- ➢ Use imagination to pretend play? (pretend to feed a baby doll) ☐ Yes ☐ No ☐ Don't Know
- ➢ Play with toys appropriately versus just mouthing, fiddling, dropping them)? ☐ Yes ☐ No ☐ Don't Know
- ➢ Speak in phrases of at least two words or more? ☐ Yes ☐ No ☐ Don't Know
- ➢ Follow one step directions? ☐ Yes ☐ No ☐ Don't Know
- ➢ Show affection spontaneously? ☐ Yes ☐ No ☐ Don't Know

Were the other milestones that were late developing (crawling, sitting up, walking)? ☐ Yes ☐ No ☐ Don't Know

If yes, please describe:

Overall, how would you describe your child's development compared to children in the same/similar age range?

Section 3: Health and Medical History

Has the child had any previous medically diagnosed conditions, syndromes, or diseases? What about currently?

☐ Yes ☐ No ☐ Don't Know

If yes, please describe:

Is the child on any prescription medications? ☐ Yes ☐ No ☐ Don't Know

If yes, please list the medications.

Has the child ever had a head injury, concussion, or loss of consciousness? ☐ Yes ☐ No ☐ Don't Know

If yes, please describe including whether medical attention was required.

Has the child gone through period in early childhood when he/she regressed, losing language and social skills?

Does the child have any history of epilepsy or seizures? ☐ Yes ☐ No ☐ Don't Know
If yes, please describe (e.g., type of seizures, physical or behavioral symptoms, duration, how often they occur)

Does the child have a hearing loss? ☐ Yes ☐ No ☐ Don't Know
If yes, please describe including if hearing aids have been prescribed.

Does the child have a vision loss? ☐ Yes ☐ No ☐ Don't Know
If yes, please describe including if glasses/correction have been prescribed.

Does the child have any issues with eating, appetite, or weight? ☐ Yes ☐ No ☐ Don't Know
If yes, please describe.

Does the child have any food allergies and/or dietary restrictions? ☐ Yes ☐ No ☐ Don't Know
If yes, please describe.

Does the child have any issues with sleep ☐ Yes ☐ No ☐ Don't Know
If yes, please describe.

Section 4: Family and Environment

Does the child have any biological family members with a history of neurodevelopmental or psychological problems?
Examples include autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), intellectual disability, speech/language delay, learning disability, depression, anxiety, etc.)

Family Member	Condition

Has the child been exposed to any traumatic events or stressors that would help us better understand him or her?

Examples include physical or emotional abuse, neglect, highly stressful events or changes such as loss of a parent due to divorce or death, living with someone abusing alcohol or drugs, etc.

☐ Yes ☐ No ☐ Don't Know
If yes, please describe.

Section 5: Child Strengths and Concerns

What are your child's strengths? What is he/she good at? What does he/she like to do?

Is your child currently eligible for or receiving special education and an Individual Education Plan (IEP) or Individual Family Services Plan (IFSP)? ☐ Yes ☐ No ☐ Don't Know

If yes, what is his/her eligibility?

How is your child doing in school?

- ➢ Academic:
- ➢ Social:
- ➢ Behavior:

Do you have any concerns regarding your child? ☐ Yes ☐ No ☐ Don't Know
If yes, describe.

Section 6: Parent/Caregiver Interview

Instructions for the interviewer: For each of the seven domains, questions have been provided to guide the gathering of information from parents/caregivers to assist in assessing historic and/or present characteristics of ASD.

The interviewer may omit questions that are not relevant due to age, developmental level or in consideration of cultural or religious variables. Interviewers are encouraged to ask follow up questions not included in this form based upon their knowledge of ASD relative to typical development.

The boxes along the left column allow the interviewer to code each item as following: H = historically, R = rarely, S = sometimes, O = often. The shading indicates a behavior that is often associated with ASD.

Domain 1: Deficits in nonverbal communicative behaviors used for social interaction including: abnormalities in eye contact and body-language, lack of facial expression or gestures, deficits in understanding and use of nonverbal communication, poorly integrated verbal and nonverbal communication.

H	R	S	O	
				1. Does s/he look at you or other in the eye when s/he wants something or when s/he is talking to you?

				2. Does your child turn his/her head to look at you when you walk up and start talking to him/her, or when you call his or her name? If No, does s/he turn his or her eyes to aoide looking at you?
				3. Does your child even use your hand like a tool, grab it and place it on what s/he wants?
				4. Does s/he use simple gestures to direct your attention or to request something, e.g., pointing at a toy, reaching up to be picked up, waving bye-bye to let you know s/he wants to go?
				5. Does your child use words and gestures together, e.g.., pointing to an object and saying “look Mommy,” waving bye-bye and saying “bye-bye,” shaking his/her head and saying “no”?
				6.Does your child use words and gestures together, e.g.l does s/he smile, frown, pout, raise his or her eyebrows in surprise? Do his/her facial expressions math the situation?
				7. Does s/he understand the expressions of other people's faces, e.g., when you frown or have an angry face, when you have a happy face?
				8. How does your child respond when you use a gesture? Will s/he look where you point to show him/her something interesting? Does s/he quiet down and pay attention when you shake your head “no”?

Domain 2: Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

First ask two general questions, “Who does s/he like to play with in the family? What types of activities or games do you (they) do together?

H	R	S	O	
				1. How does s/he let you know s/he wants you to pay attention to him/her or play with him/her, e.g. does s/he bring a toy or book to you? *(Clarify whether s/he bring a book or toy to engage parents in play and not just to get help; also ask how often s/he plays by him/herself vs trying to engage parents or siblings in play.)*
				2. If you say “I’m going to get you” or cover your eyes for peek-a-boo, does your child get excited because he/she knows what’s going to happen next? Does he/she request you do it again (e.g., by getting excited, grabbing your hand or saying “more”)?
				3. Will he/she play imitative games such as pat-a-cake, peek-a-boo or “so big?” Will he/she cover his or her face to play peek-a-boo with you? Does he/she request you do it again?
				4. Will s/he copy or imitate you when you make nonsense sounds like raspberries or tongue clicking?
				5. Will your child imitate you when you stick out your tongue or make faces? Does s/he imitate you when you wave bye=bye, clap your hands for pat-a-cake or share your head “no”? Does s/he try to imitate you if you shake a rattle or other toy?

				6. Will s/he imitate you when you are doing housework such as dusting, sweeping or cooking? Does s/he give a hug or pretend to feed or take are of a doll or stuffed animal? Does she