-DEVELOPMENTAL INTERVIEW
For Suspected Autism Spectrum Disorder
Date:_____

Child's Name _____Birth date:_____ Male Female
Address:_____ Age _____ Ethnicity_____
_____ Primary Home Language_____
City State Zip
Home Phone _____ Primary Cell Phone _____

Parent Name _____ Parent Name_____
Address: _____ Address: _____
Occupation _____ Occupation _____
Employer _____ Employer _____
Work Phone _____ Work Phone _____
Primary Email _____ Primary Email _____

Siblings

	Name	Date of Birth	Gender	Age	Significant Medical Information
1.					
2.					
3.					
4.					

Others Living in the Home:

Family Health History: (any inherited or family disease processes, disabilities, significant health problems known in child's biological family)

Prenatal and Birth History: (any complications pre-natal, birth or following birth)

Weeks Gestation: Type of delivery: Birth weight:

Pertinent Information regarding neonatal period: (first 28 days)

___No concerns	___ jaundice	___ oxygen needs
___Difficulty eating	___respiratory distress	___ infections
___ Bottle fed	___ breast fed	___ Other

Describe anything checked above:

Sensory System Review:
Vision: Formally Evaluated? Yes or No When:
Results:
Do/did you have concerns about your child's vision? **(ie: starring; holds objects close to his/her eyes; difficulty 'catching' his/her eye gaze; likes to look at lights,**

fans, or other objects)

Comments:

Hearing: Formally Evaluated? Yes or No When:
Results:
Do/did you have concerns about your child's hearing **(i.e.:lack of response or ignored sounds; delayed responses; covers ears when noisy; other)**

Comments:

Touch/ Tactile	Does/did your child:	Yes	No
	Avoid/become irritated by certain clothing		
	Show Sensitivity to certain textures/temperatures:		
	Persistently mouth objects over the age of 1 year:		
	Over/Under react to mild pain:		
	Resist Bathing, brushing teeth, haircuts:		
	Exhibit clingy behavior		
	Show discomfort when approached or touched		
	Insist on a large "personal space"		
	Have picky eating habits:		

Vestibular:	Does or did your child:	Yes	No.
	Fall or trip often?		
	Lose balance easily		
	Have problems hopping or skipping		
	Like to rock, swing or spin		
	Resist movement activities		
	Bump into objects, walls, doors		
	Use one hand for two-handed activities		
	Other:		
	Comments:		

Proprioceptive: (Awareness of Body in space)	Does or did your child:	Yes	No.
	Flap hands, stamp feet, clap, jump to unusual degree		
	Toe walking		
	Climb in inappropriate places		
	Bangs Head		
	Grind/Clench teeth		
	Exhibit Clumsy/awkward movements		
	Touch/Holds objects lightly		
	Have difficulty positioning self on furniture		
	Become physically rough with others/objects		
	Comments:		

Speech and Language Development:
Describe early concerns, if any, regarding your child's speech/language development (ie: delays, echoing, jargon speech, repetitive speech, pronoun reversals.)

What is your child's current mode of communication?

___ babble ___ sentences ___ bi-lingual
___ gestures ___ asks questions
___ few words ___ no verbal speech ___ Other notes:
___ phrases ___ sign language

Does/did your child: If yes, describe:

Coo/babble as an infant?
Respond to/look towards or voices?
Imitate actions (ie: so big / bye bye)
Imitate sounds (ie: vehicle, animal environmental)
Imitate Words? Vs. Echo words?
Use Gestures/facial expressions to indicate wants/needs?
'Catch' your gaze when communicating with you?
Respond to simple one step directions?
Use words and then appear to 'lose' them?

Comments:

Describe current concerns, if any, regarding your child's communication (ie: rarely initiates conversations, had difficulty understanding humor, likes to talk about topics narrow topics of strong interest to him/her).

(If child is verbal) Does your child demonstrate any of the following?

Reduced vocal intonation Monotone, or odd intonation in voice yes no
Unusual use of loudness/volume or pitch in his/her voice yes no
Minimal or lack of non-verbal 'body language' or gestures yes no
Limited use of descriptive language yes no
Difficulty understanding non-verbal cues including facial expressions
Tone of voice, gestures yes no
Trouble understanding irony, humor, sarcasm, yes no
Perception of the world in more concrete/literal manner? Yes no
Tendency to engage in one-sided conversations about a
Favorite topic? Yes no
Difficulty building on conversations/turn taking yes no

Comments:

Emotional and Social Development:

What concerns, if any, do you have regarding your child's behavior/social skills?

As an infant, did your child like to be held and cuddled? Yes no
Was your child content and easy going? Yes no
Could your child be content to be alone playing for long periods of time? Yes no
Did/does your child seem to enjoy toys/objects more than people? Yes no

As a young child, how did your child interact with other children their same age?

Older or younger children?

Adults?

Does/did your child demonstrate emotional reactions that seemed unconnected to the events/objects around them? Yes no Comment:

Does your child:

Eagerly seek out new people or activites? Yes no
Appear ore interested in objects than in people? Yes no
Use inappropriate or odd ways of approaching people? Yes no
Have difficulty making / maintaining friendships? Yes no
Seem insensitive to other person's feelings? Yes no
Seem inflexibility in negotiating shared activities? Yes no
Seem frustrated due to repeated failures to engage others Or make friends. Yes no
Have a strong desire for rules, routines or ridged social conventions? Yes no

Comments:

Repertoire of activities and interests:

As an infant/young child what were some of your child's favorite activities/toys?

Does/did your child engage in what might be considered odd or inappropriate play for prolonged periods? Yes No Comment;

Does/did your child demonstrate a strong persistent interest in certain activities, toys, topics, movies, or games? Comment:

Does/did your child over-react to changes in routines or schedules? Comment:

Does/did your child seem overly concerned with order and routine in his/her play? (ie: lining things up, strong preference for things being done in a certain order). Comment:

Does/did your child demonstrate an insistence on following certain routines/rituals?
Comments:

Does or did your child have any seemingly unreasonable fears, anxious reactions to the fears?
Comments:

Acquisition of Skills:
Does or did your child show an interest letters, numbers under the age of 3? Comment:

Does/did your child have difficulty learning new skills? Comment:

Does/did your child demonstrate any unusual or seemingly advanced skills such as an amazing memory, musical skills, and math skills? Comment:

School History

Did your child attend a preschool or preschool based day care? Yes no
If so, what age and where?

Where has your child attended school? List chronologically

What special services has your child received in private therapies or in schools?

What, if any, concerns have his/her teachers noted?

Does/did your child participate in any recreational activities? Have these been positive experiences for your child?

Miscellaneous Notes:

Cooperative

Adapted from interview Developed by Renae Diener
Sherburne & N. Wright Special Education

302 Washington St Monticello, MN 55362
(763) 272-2050

Date: _____

Name: _____ Setting: _____ # of Adults: _____

DOB: _____ Activity(s): _____ # of Children: _____

SOCIAL INTERACTIONS:

-Limited joint attention
-Limited use of facial expressions directed toward others
-Does not bring/show things to others to indicate interest
-Gross impairment in ability to make and keep friends
-May appear to prefer isolated or solitary activities
-Misinterprets others' behaviors and social cues

COMMUNICATION:

-Not using a finger to point or request
-Using others' hand or body as a tool
-Lack of spontaneous imitation
-Lack of varied imaginative play
-Absence or delay in spoken language
-Limited understanding of nonverbal communication
-Odd production of speech (intonation, volume, rhythm or rate)
-Repetitive or idiosyncratic language
-Inability to initiate or maintain a conversation

RESTRICTED, REPETITIVE or STEREOTYPED PATTERNS of BEHAVIOR, INTEREST and ACTIVTIES:

-Insistence on following routines or rituals
-Demonstrates distress or resistance to changes
-Repetitive hand or finger mannerisms
-Lack of true imaginative play vs. reenactment
-Overreaction or under-reaction to sensory stimuli
-Rigid or rule-bound thinking
-Intense, focused preoccupation with a limited range of play, interests or conversation topics

Time: _____

Time: _____

Time: _____

Time: _____

Time:

Time:

Time:

Time:

Time:

Time: