

Parent Questionnaire

Child's Name: _____ Date of Birth: _____ Date of Screen: _____

Please complete this form before today's visit with your child's physician. Answers should indicate how your child usually behaves. Please try to answer every question. If the behavior is rare (i.e., you've seen it once or twice), please answer as if the child does not engage in the noted behavior. To indicate "Yes" or "No," completely fill in appropriate square with pencil or pen.

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

Responses in Red	<input type="checkbox"/>
Responses in both Red and Blue	<input type="checkbox"/>
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