

**CHEBOYGAN • OTSEGO • PRESQUE ISLE
EDUCATIONAL SERVICE DISTRICT**

6065 Learning Lane
(231) 238-9394



Indian River, MI 49749
(231) 238-8551 (fax)

**DEVELOPMENTAL AND SOCIAL HISTORY FOR
SUSPECTED AUTISM SPECTRUM DISORDER**

Student Name:

Parent(s)/Guardian(s):

D.O.B:

Address:

School:

Grade:

Phone:

Date of Interview:

Interviewer:

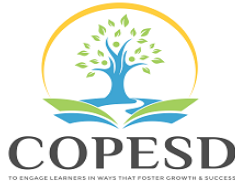
Method of Interview:

FAMILY INFORMATION				
<i>Family Members (living in home?)</i>	<i>Relationship</i>	<i>DOB/AGE</i>	<i>Employment/Education</i>	<i>Health Problems, Concerns?</i>

DAYCARE/SCHOOL EXPERIENCE:		
<i>Date</i>	<i>Setting</i>	<i>Concerns?</i>

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AGENCY INVOLVEMENT:

CMH: _____ Respite _____ Family Subsidy _____ Case Manager: _____ Wraparound _____

Other: _____

Does COP or School have a Release of Information for these agencies? _____

BACKGROUND INFORMATION:

MEDICAL INFORMATION:

Health History: _____

Current Health Concerns: _____

Current

Diagnoses: _____

Medication: _____

Physician: _____

Hearing Exam: ___ Yes ___ No Results: _____

Vision Exam: ___ Yes ___ No Results: _____

PARENT CONCERNS:

1. _____

2. _____

3. _____

4. Age at which you first noticed something was not quite right regarding these concerns: _____

5. What was the first symptom to arouse your concern?: _____

PRENATAL AND EARLY DEVELOPMENT:

PRENATAL:

Health/Complications (trauma, alcohol/drug use, etc) _____ No complications

Gestation: _____

Type of delivery ___ Natural ___ Cesarean

Length of Labor: _____

Anesthesia: _____

Weight: _____

Length: _____

Apgar Score: _____

Complications: ___ Oxygen ___ Resuscitation ___ Jaundice/ Treatment: _____

Other: _____

Discharged with mother: ___ Yes ___ No If no, length of hospital stay: _____

Bottle fed: ___ Yes ___ No Until: _____

Breast fed: ___ Yes ___ No Until: _____

Complications/Difficulties (drooling/sucking/etc): _____

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Reaction to introduction of baby food: _____

Sleep history (slept through the night, nightmares/terrors, changes, etc.)

Rocking or unusual behaviors during sleep? _____

Description of child as a baby/infant: _____

DEVELOPMENTAL MILESTONES:

<u>Skill</u>	<u>Age</u>	<u>Skill</u>	<u>Age</u>
Sat unsupported:	_____	Bladder trained:	_____
Stood with Support:	_____	Bowel trained:	_____
Crawled:	_____	Spoke first words:	_____
Walked alone:	_____	Spoke in sentences:	_____
Unusual walk:	_____	Used utensils:	_____
Drank from a cup:	_____		

Loss of skills in any areas of development: ___ Yes ___ No _____

Loss of language skills after acquisition? _____

Any illness or traumatic events at the time of loss? _____

SOCIAL HISTORY:

Babbled with expression: ___ Yes ___ No

Responded to familiar voices by cooing, attending, or smiling? ___ Yes ___ No

Initiate social smiling: ___ Yes ___ No

Established eye contact (explored adult features, showed interest in people by gaze and/or body position) ___ Yes ___ No _____

Turned in the direction of people/sounds ___ Yes ___ No _____

Reached out arms to be picked up ___ Yes ___ No _____

Molded and relaxed body when held; cuddled ___ Yes ___ No _____

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Enjoyed a great deal of physical contact ___ Yes ___ No _____

Responded to social play (games like “Tickle”, “This Little Piggy”) ___ Yes ___ No _____

Participated in social games (Peek-a-boo, Pat-a-cake, e t c) ___ Yes ___ No _____

Waved good bye ___ Yes ___ No

Extended toys to show others ___ Yes ___ No

Showed anxiety over separation from parent/care-giver ___ Yes ___ No _____

Displayed stranger anxiety: ___ Yes ___ No _____

Other: _____

**CURRENT DEVELOPMENT:
SOCIAL INTERACTION**

Does he/she notice other people (include family members)? _____

How does he/she respond to interaction by or from others (gestures, commands, use of name, etc)? ___

Does he/she seek to share enjoyment with others? _____

Has he/she developed relationships with anyone (family, caretaker, significant other?) _____

Does he/she display quality social overtures? _____

Does he/she offer comfort to others? _____

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How does he/she react when caretakers leave? _____

How does he/she respond to strangers (approach, avoid, ignore)? _____

Does he/she engage in reciprocal use of eye contact (initiate, sustain, etc)? _____

Does he/she display a range of facial expressions? _____

Does he/she recognize others facial expressions/tone of voice? _____

Other: _____

EMOTIONAL/BEHAVIORAL RESPONSE:

Does he/she have mood changes and/or temper tantrums? Describe (frequency, duration, warning signs, etc):

Is he/she difficult to console? _____

Does he/she exhibit self-abusive behavior (head banging, biting, hitting, etc)? _____

Does he/she exhibit aggressive behavior toward others? _____

Is he/she destructive (frequently damage or destroy property)? _____

Does he/she show a variety of emotions (happy, sad, excitement, sympathy, etc)? _____

Does he/she exhibit laughing or inappropriate silliness for no apparent reason? _____

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Does he/she exhibit inappropriate facial expressions? _____

Does he/she cry for no apparent reason? _____

Is his/her body posture unusually stiff or loose? _____

Does he/she exhibit fear of objects, people or situations without reason? _____

Does he/she display an over or under response to pain? _____

Does he/she lack fear of danger? _____

PLAY

What are his/her favorite activities? _____

Does he/she play appropriately with toys? _____

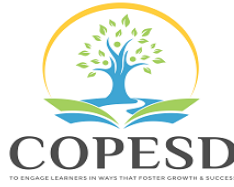
Does he/she engage in imitative and/or imaginative play? _____

How does he/she interact with peers (parallel play, interactive games, turn taking, sharing, etc)? _____

How does he/she respond to social initiation by peers? _____

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Does he/she initiate play with others? _____

Is he/she able to sustain play (stick with activity, control activity, must win, etc)? _____

Does he/she have any friends? _____

How does he/she respond when someone interferes with his/her play? _____

Does he/she exhibit an inappropriate attachment to an object? _____

**RESTRICTED INTERESTS/ STEREOTYPED PATTERNS OF BEHAVIOR, INTERESTS AND
ACTIVITIES**

Does he/she insist on any daily routine? _____

Does preparation for change alter his/her reaction to change? _____

How does he/she react to being interrupted from what he/she is doing? _____

RESTRICTED INTERESTS CONTINUED

Is he/she upset by changes in his/her environment (furniture arrangement, things that are not 'right' such as a crooked picture, etc)? _____

Does he/she engage in rituals (lining up objects, insisting upon taking the same route between two places, repetitive motions, etc) and become upset if they are disturbed? _____

Does he/she show a narrow focus of interests? _____

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Does he/she persevere or continue an activity when it is no longer appropriate? _____

Does he/she exhibit a preoccupation with spinning, flipping, or twirling objects? _____

Does he/she show a preoccupation with mechanical objects and/or parts of objects
(fans, radios, vacuum cleaner, etc) ?

Does he/she show any other unusual preoccupations? _____

Does he/she exhibit inappropriate physical behavior such as running, jumping, or perpetual motion for no apparent
reason? _____

Does he/she rock, flap arms/hands/legs, hold self in awkward ways, exhibit inappropriate gestures/facial grimaces or
move body in unusual ways? _____

Does he/she whirl/spin without apparent dizziness? _____

Other: _____

COGNITIVE SKILLS:

Does he/she have difficulty adding new skills to existing skills? _____

Does he/she have an usually good memory? _____

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Does he/she show an unusual degree of skill in any area (visuospatial, musical, drawing, reading, computational, etc)? _____

COMMUNICATION:

Does he/she use gestures to communicate (or supplement verbal communication of) wants and needs?

Does the child echo questions or statements made by others (in person or from TV/movies)? _____

Does the child repeat any phrases over and over? _____

Does the child use pronouns incorrectly? _____

Describe the child's voice tone (monotone, use of inflection, rate, volume, tone, professor like): _____

Does he/she engage in reciprocal conversation? _____

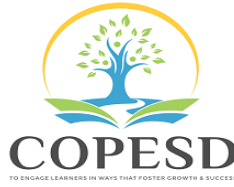
Does he/she engage in social conversation or 'chatting'? _____

Does he/she ask or make inappropriate questions or comments? _____

Does he/she use idiosyncratic language? _____

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SENSORY/MOTOR:

Auditory:

- Startle response
- Responds when name is called
- Distracted by auditory stimuli
- Withdraws from/covers ears
- Turns in the direction of sound
- Selectively attends to voice/sounds
- Unusual response to types/levels of sound
- Self induced sounds (humming, etc)

Visual:

- Stares into space for prolonged periods
- Finger or hand stares
- Closely regards spinning objects
- Distracted by visual stimuli
- Stares through or next to people or objects
- Stares at lights, reflections, shiny objects, etc
- Scrutinizes objects or focuses on background
- Withdraws from/ covers eyes/closes eyes

Tactile:

- Self stimulating behavior (rocking, etc)
- Refuses to use hand/uses others
- Resists/withdraws from tactile input (touch, etc)
- over/under response to temperature or pain

Smell

- Frequently smells or sniffs objects

Taste:

- Strong preferences/aversions to foods
- licks or mouths things to explore objects
- Eating oddities (refusing to drink from certain container, eating only one or two foods, insisting on food at certain temperature)

Motor:

- Fine/Gross Motor Concerns
- Falls/gets hurt easily
- Unusually skillful in doing fine work with fingers or playing with small objects
- Walks on toes
- Difficulty with balance

ADDITIONAL PARENT INPUT/RECOMMENDATIONS:

How would you describe your child? _____

What are your child's strengths? _____

What are your hopes for your child? _____

What type of educational programming does your child need to be successful? _____
