LDDC Parent Questionnaire (add additional sheets as needed)

PATIENT NAME: ______________________________ PATIENT'S DATE of BIRTH: __________

1 What questions would you like answered as a result of this evaluation?

2 Please list and describe any concerns you have about your child's emotional wellbeing (anxiety, depression, etc).

3 Please list any concerns you have about your child's behavior.

At home:

At school:

4 Please list any concerns you have about your child's social skills (ability to make/keep friends, plays skills).

5 List any concerns about sensory issues with your child (sensitivity to sound, light, texture, touch, etc).

6 Briefly describe your child's growth and general health, as well as, any family medical/mental health history you think we should know about.

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7 Please list prescription medications and dosages your child is currently taking:

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8 How is your child doing with learning:

Reading

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Writing

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Math

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9 Who does your child currently live with?

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10 Do you or others have concern that your child shows signs of Autism Spectrum disorder?

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11 Is there anything else that you feel is important for us to know about your child?

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Name of person completing this form: ______________________ Relationship to child ______________

Date form completed: ______________

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