The University of Florida
Department of Psychiatry
Division of Child and Adolescent Psychiatry
AUTISM PROGRAM QUESTIONNAIRE

YOUR CHILD'S NAME: _____NICKNAME:_____

DATE OF BIRTH:_____AGE:_____

ADDRESS_____

YOUR TELEPHONE (S)_____

DATE QUESTOINNAIRE COMPLETED: _____

COMPLETED BY:_____RELATIONSHIP:_____

Who referred you to us?_____Why?_____

_____

Information about the Child and Family

Child's Sex: Male_____ Female_____

Mother's Name:_____ Age:_____ Occupation:_____

Father's Name:_____Age:_____ Occupation:_____

Mother completed: High School_____ Some College_____ College Graduate_____

Father completed: High School_____ Some College_____ College Graduate_____

Parents are: Married_____ Divorced_____ Separated_____ Never Married_____

Child currently lives with:_____

Child's legal guardian (s):_____

Other children in the family:

NAME	Age	List any problems or special needs
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there other people in the home? YES_____NO_____What is their relationship to your child?_____

Are there pets in your home? YES____NO____Please list:_____

_____

Do you live in: ____an apartment_____mobile home____house