IF YOU ANSWERED **YES** TO ANY OF THE ABOVE QUESTIONS, PLEASE DESCRIBE BELOW:

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WE WOULD LIKE TO KNOW HOW YOU ARE DOING:

	YES	NO
How many hours of uninterrupted sleep do you usually get each night?_________		
Does your child sleep with you?		
Most days do you feel: tired___ rested ___ exhausted___ full of energy____		
Do you have a physician for yourself?		
Do you have any current medical problems?		
If YES, please describe:		
Do you take prescription medication for any reason?		
Do you currently take a daily multi-vitamin?		
Do you eat regular meals?		
You engage in physical exercise or a relaxation activity: daily___ 1-2 times per wk___ hardly ever___ not at all____		
On most days your mood is: good___ fair___ not so good____		
How do you cope with stress? Pretty good___ fair___ not so good____		
Are there days when you feel overwhelmed?		
Do you have anyone you can depend on to help you with your child?		
Are you confident in your child's physician?		
Do you feel you can be honest and openly discuss your concerns about your child with his/her physician?		
Do you attend any support groups?		
Do you feel your psychological needs are met?		

If you would like to add anything, please do so in the space below:

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THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. WE HOPE THAT THE INFORMATION YOU HAVE PROVIDED WILL HELP US TO BETTER UNDERSTAND YOUR CHILD AND PROVIDE YOUR FAMILY WITH THE BEST CARE.

THE UNIVERSITY OF FLORIDA AUTISM TEAM