



Study to Explore Early Development

Services and Treatment Questionnaire

SECTION A: Classroom programs

Many children participate in classroom-based preschool programs:

A1. Has your ever child attended a classroom program?

YES

NO

DON'T KNOW

Go to Section B

Go to question A3

A2. When did he/she begin attending a classroom program?

___ / ___ (MM/YYYY)

A3. Does your child currently attend a classroom program?

YES

NO

DON'T KNOW

Go to A5

Go to A4

Go to Section B

A4. When did he/she stop attending the classroom program?

___ / ___ (MM/YYYY)

If your child is not currently attending a program,
skip to Section B

A5. How many children are in your child's current class?

___ children

A6. Does your child have a 1:1 aide or a shadow or aide full-time or part-time?

NO

YES – FULL-TIME

YES – PART-TIME

DON'T KNOW

A7. How many days per week does your child attend this school program?

___ days

A8. How many hours per day does your child attend this school program?

___ hours

Public Reporting Burden Statement

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0741)

A9. Is this a special program that is related to your child's disability?

YES

NO

DON'T KNOW

SECTION B: Professional Individual and Group Services

B1. Has your child ever used any of the following services to meet his/her developmental needs? *Note: services can be received anytime, either in/outside of school.*

Services	YES	NO	DON'T KNOW
Behavior modification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respite care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory Integration therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Skills training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify and rate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If YES to any of the above, go to question B2

If NO or DON'T KNOW for all the above services, go to question B3.

B2. How many service hours does your child currently receive per week?

_____ Hours per week

B3. Has your child ever seen any of the following service providers for his/her developmental needs? *Note: providers can be either in/outside of school.*

Service Providers	YES	NO	DON'T KNOW
Audiologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Pediatrician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutritionist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurse (home/long-term care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paraprofessional Indicate type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify and rate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If YES to any of the above, go to question B4

If NO or DON'T KNOW for all the above service providers, go to Section C

B4. How many hours per week does your child currently work with these service providers?
____ Hours per week

SECTION C: Complementary and Alternative Medicines (CAM), Therapies, Interventions

C1. What special diets, vitamins, food supplements, alternative treatments [including over-the-counter medications, prescriptions, or special injections to treat your child's developmental problems], or interventions your child has ever received that were not previously reported.

See lists on pages 4-5 for examples of CAM, therapies, and interventions and lists on page 5 for over-the-counter medications..

- Medicine/Treatment 1: _____
- Medicine/Treatment 2: _____
- Medicine/Treatment 3: _____
- Medicine/Treatment 4: _____
- Medicine/Treatment 5: _____
- Medicine/Treatment 6: _____
- Medicine/Treatment 7: _____
- Medicine/Treatment 8: _____
- Medicine/Treatment 9: _____
- Medicine/Treatment 10: _____

C2. What special diets, vitamins, food supplements, alternative treatments [including over-the-counter medications, prescriptions, or special injections to treat your child's developmental problems], or interventions is your child currently receiving that were not previously reported?

See lists on pages 4-5 for examples of CAM, therapies, and interventions..

- Medicine/Treatment 1: _____
- Medicine/Treatment 2: _____
- Medicine/Treatment 3: _____
- Medicine/Treatment 4: _____
- Medicine/Treatment 5: _____
- Medicine/Treatment 6: _____
- Medicine/Treatment 7: _____
- Medicine/Treatment 8: _____
- Medicine/Treatment 9: _____
- Medicine/Treatment 10: _____

Herbal Medications and Alternative Treatments

Herbal Medications

Absinthe	Borage	Ephedra	Kava	Saw Palmetto
Aloe	Chamomile	Feverwort	Licorice	St. John's Wort
Angelica	Chicory	Frankincense	Ma Huang	Senna
Arnica	Chondroitin	Gingko	Milk Thistle	Southernwood
Belladonna	Dong Quai	Ginseng	Noni	Valerian
Black Cohosh	Echinacea	Glucosamine	Red Clover	Wormwood
Birch	Eucalyptus	Horse Chestnut	Rooibos	Yarrow

Natural and/or vitamin supplements

B6 and Magnesium (SuperNuThera)	Melatonin
Carnosine	Methyl-B12 (oral or shot)/ Methylcobalamin (concentrated Vitamin B12) injections
Cod Liver Oil	Tryptophan
D-Cycloserine	Tyrosine
DMG (Dimethylglycine)	Vitamin A (as cod liver oil)
Fatty acids (EFA) or Omega 3 Fatty Acids	Vitamin B12
Folic acid	Vitamin C
Grapefruit seed extract	Vitamin Supplements (other)

Gastrointestinal treatments

Acidophilus/ mixed probiotics	Pepcid
Alkaline Salts	Secretin
Bethanecol/ urocholone	Oxidative stress
Epsom Salt baths	Glutathione (oral, transdermal, or IV)
Enzyme aide	Thiamine tetrahydrofurfuryl (TTFD); Allithiamine (Transdermal TTFD)
Histamine 2 blockers – Cimetadine (Zantac)	

Anti-infectives or immune

Antibiotic therapy	Natural anti-virals: Lauricidin, Larch araginogalactins, IP-6 (Inositol hexaphosphate), Myco-Immune
Antifungal (anti-yeast) agents (Nystatin, Diflucan)	Transfer factor
Antiviral: Valtrex (for herpes); Acyclovir, Famvir, Immunovir	Vancomycin
Aqua Flora (anti yeast)	Withhold immunization(s)
Colostrum	Antibiotic therapy
Immunoglobulins Intravenous or Oral, BayGam	

Diets

Gluten free/casein free	Yeast Free
Specific Carbohydrate Free	Other elimination diet (e.g., Finegold, sugar free, others)

Chelation (for mercury)

Chelators: DMSA
 Natural chelators: alpha lipoic acid

Other

Oxytocin
 Hyperbaric Oxygen (HBOT)
 Chiropractic Care

Over-the-Counter Medications

Pain Reliever/Fever Reduction/Cold/Flu/Allergy		
Acetaminophen	Dimetapp	Oxymetazoline
Advil, Children's	Diphenhydramine HCl	Pseudoephedrine HCl
Afrin	Dristan 12-hour nasal spray	Robitussin
Benadryl	Guaifenesin	Sudafed
Chlorpheniramine maleate	Ibuprofen	Triaminic
Chlor-Trimeton	Motrin, Children's	Tylenol, Children's
Cromolyn sodium	Nasal Crom Allergy Prevention	Vicks Sinex 12-hour nasal spray

Constipation	
STIMULANT	<u>ORAL</u>
Fleet Suppositories	Magnesium Citrate
Dulcolax suppositories	Magnesium Hydroxide (Phillips' Milk of Magnesia)
Senna (Senkot)	<u>OTHER</u>
STOOL SOFTENER (Emollient)	Glycerine Suppositories
Children's Colace	Lactulose
Mineral oil	