Form Approved
OMB No. 0920-XXXX
Exp. Date: XX/XX/20XX

Attachment 8.h.

Study ID #: ______________
Date of Completion:_______

Study to Explore Early Development

Services and Treatments Questionnaire

Public reporting burden of this collection of information is estimated to average 10 minutes, 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 (0920-0010).

Many children participate in classroom based preschool programs, individual group programs, complementary therapies, alternative therapies, or other therapies to meet their developmental needs. We would like to get a sense of the types of services and treatments your child has received. Has your child ever used any of the following services or therapies?

Service	NO/ DON'T KNOW	YES	Age at first service date (any location; (specify years and months)	Is child still receiving service?	IF NO: Age at last service date (any location; specify years and months)	IF YES: Total Hours per week	IF YES: Service takes place… (check all that apply)
Preschool program (general)	☐	☐	_____years & ____ months	Yes No	_____years & _____ months		Enter IN school
Preschool program (special needs)	☐	☐	_____years & ____ months	Yes No	_____years & _____ months		Enter IN school
Respite care	☐	☐	_____years & ____ months	Yes No	_____years & _____ months		Enter OUT of school
ABA Behavior modification	☐	☐	____years & ____months	Yes No	____years & _____ months		☐ in school ☐ out of school
Classroom aide, para-educator or shadow	☐	☐	_____years & ____ months	Yes No	_____years & _____ months		☐ in school ☐ out of school
Occupational therapy, including sensory therapy	☐	☐	_____years & ____ months	Yes No	_____years & _____ months		☐ in school ☐ out of school
Physical therapy	☐	☐	_____years & ____ months	Yes No	_____years & _____ months		☐ in school ☐ out of school
Social skills training	☐	☐	_____years & ____ months	Yes No	_____years & _____ months		☐ in school ☐ out of school
Speech language therapy	☐	☐	_____years & ____ months	Yes No	_____years & _____ months		☐ in school ☐ out of school
Other: specify:_____________	☐	☐	_____years & ____ months	Yes No	_____years & _____ months		☐ in school ☐ out of school
Other: specify:_____________	☐	☐	_____years & ____ months	Yes No	_____years & _____ months		☐ in school ☐ out of school
Other: specify:_____________	☐	☐	_____years & ____ months	Yes No	_____years & _____ months		☐ in school ☐ out of school

In the next sections, note the types of additional therapies your child has ever received and the types of medications he or she has ever been prescribed to treat behavioral symptoms.

	NO/			Is child still	IF NO:	If EVER used,

Complementary or alternative therapies ever used to treat behavioral symptoms	DON'T KNOW	YES	Age when first used (specify years and months)	receiving treatment?	Age when last used (specify years and months)	Specify type of therapy or diet
Chelation therapy	☐	☐	______years & _____ months	Yes No	______years & ______ months	
Chiropractic Care or massage therapy	☐	☐	______years & _____ months	Yes No	______years & ______ months	
Diet: Gluten and/or Casein Free	☐	☐	______years & _____ months	Yes No	______years & ______ months	
Diet: Yeast Free Diet	☐	☐	_____years & _____months	Yes No	_____years & ______ months	
Diet: Other	☐	☐	______years & _____ months	Yes No	______years & ______ months	
Dietary or Vitamin Supplements	☐	☐	______years & _____ months	Yes No	______years & ______ months	
Herbal supplements, medication or tea	☐	☐	______years & _____ months	Yes No	______years & ______ months	
Hyperbaric Oxygen Therapy	☐	☐	______years & _____ months	Yes No	______years & ______ months	
Immune treatments (e.g. stem cell transplants or antibiotic or antiviral therapies)	☐	☐	______years & _____ months	Yes No	______years & ______ months	
Other: specify:________________	☐	☐	______years & _____ months	Yes No	______years & ______ months	
Other: specify:________________	☐	☐	______years & _____ months	Yes No	______years & ______ months	
Other: specify:________________	☐	☐	______years & _____ months	Yes No	______years & ______ months	

Medications ever used to treat behavioral symptoms	NO/ DON'T KNOW	YES	Age at first dose (specify years and months)	Is child still receiving medication?	IF NO: Age at last dose (specify years and months)	If EVER used, Specific name(s) of medication(s)
Antidepressants, anti-anxiety, or obsessive-compulsive medications, such as Prozac or	☐	☐	______years & _____ months	Yes No	______years & ______ months	

Zoloft						
Atypical Antipsychotics, such as Risperdal or Abilify	☐	☐	_____years & ____ months	Yes No	_____years & _____ months	
Medications used to treat seizures and/or stabilize mood, such as Tegretol, Lamictal	☐	☐	____years & ____months	Yes No	____years & _____ months	
Non-stimulant medications used to treat hyperactivity or inattention, such as Tenex or Clonidine	☐	☐	____years & ____ months	Yes No	_____years & _____ months	
Stimulant medications often used to treat hyperactivity or inattention, such as Ritalin or Adderall	☐	☐	_____years & ____ months	Yes No	_____years & _____ months	
Other medication	☐	☐	_____years & ____ months	Yes No	_____years & _____ months	
Other medication	☐	☐	_____years & ____ months	Yes No	_____years & _____ months	
Other medication	☐	☐	_____years & ____ months	Yes No	_____years & _____ months	
Other medication	☐	☐	_____years & ____ months	Yes No	_____years & _____ months	

END QUESTIONNAIRE

Common Medications Used to Treat Symptoms of Autism Spectrum Disorders

Antidepressant, anti-anxiety, and obsessive-compulsive medications:

- Zoloft® (Also called sertraline.)
- Prozac® (Also called fluoxetine.)
- Paxil® (Also called paroxetine.)
- Effexor® (Also called venlafaxine.)
- Wellbutrin® (Also called buproprion.)
- BuSpar® (Also called buspirone.)

Atypical antipsychotics (commonly used to treat irritability and/or challenging behaviors):

- Risperdal® (Also called risperidone.)
- Abilify® (Also called aripiprazole.)
- Seroquel (Also called quetiapine.)
- Zyprexa® (Also called olanzapine.)
- Clozaril® (Also called clozapine.)
- Haldol® (Also called haloperidol.)
- Mellaril® (Also called thioridazine.)
- Orap® (Also called pimozide.)

Hypertension agents (as alpha adrenergic agonists, commonly used to hyperactivity and inattention):

- Tenex® (Also called Guanfacine.)
- Clonidine® (Also called Catapres.)

Medications used to treat seizures and/or stabilize mood:

- Depakote® (Also called valproic acid.)
- Tegretol® (Also called carbamazepine.)
- Cibalith-S® (Also called lithium citrate.)
- Eskalith® (Also called lithium carbonate.)
- Lithobid® (Also called lithium carbonate.)
- Lamictal® (Also called lamotrigine.)

Stimulant Medications (often used to treat hyperactivity and inattention):

- Ritalin® (Also called methylphenidate.)
- Concerta® (Also called methylphenidate.)
- Metadate® ER (Also called methyphenidate.)
- Adderall® (Also called amphetamine.)
- Cylert® (Also called pemoline.)
- Dexedrine® (Also called dextroamphetamine.)
- Dextrostat® (Also called dextroamphetamine.)
- Focalin® (Also called dexmethylphenidate.)
- Strattera® (Also called atomoxetine.)
- Daytrana® (Also called methylphenidate transdermal patches.)