KINGS BRIDGE *Private Hospital*

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Adult ASD Assessment

Pre-Clinic Questionnaire

Please note there are questions relating to pregnancy, birth, first year of life and developmental milestones. If possible, please answer with a parent and/or family member who knows this information.

Details

Surname:		**Forename(s):**	
Address:			
DOB:		**Sex at Birth:**	**Gender Identity**
Primary Language:		**Other languages spoken at home:**	
Have you been assessed for ASD before?	**Yes** ☐	**No** ☐	

Parent/Guardian Details

Surname:		**Surname:**	
Forename(s):		**Forename(s):**	
Current Address:		**Current Address:**	
Contact number:		**Contact number:**	
Email:		**Email:**	

Who do you currently live with?	

Are you currently in a relationship?

Name of partner:	
Relationship history: (status, length etc.)	

Consent for Contact

In preparation for your assessment, it is sometimes necessary to obtain additional information from other individuals or agencies. Please complete and sign the following form as stating your permission to contact those who are/have been involved with you.

GP Details

GP Name:		**Address:**	
Contact number:			

I give permission for the above to be contacted?	**Yes**	**No**

NIECR	**Do you give permission for the clinicians to access your electronic health record:**	**Yes**	**No**

Risk Assessment	Past	Present	Any additional comments on risk?
Self-Harm			
Suicidal ideation			
Drug use			
Alcohol use			
Forensic history (any policemen involvement/ jail time)			
Aggression			
Violence			

Medical & Mental Health Background

Existing Diagnoses			
Diagnosis	**Age when diagnosed** (Years Months)	**Type of professional who made diagnosis (e.g. psychologist, psychiatrist, paediatrician)**	**Prescription Medication**

Hospitals/Clinics/Local Mental Health Services

Clinician's Name:	
Dates Attended:	
Contact Number:	
Email:	

Name of Clinic/ Hospital:	

I give permission for the above to be contacted?	**Yes** ☐	**No** ☐

General Physical Health – Please describe your general health currently and past.

Mental health and emotional wellbeing — Please describe your general emotional and mental health currently and past and if they have had any intervention in this area.

Have you experienced any traumatic events in your life?
Include any family trauma history that you think is relevant here.

Have you experienced any of the following:

Seizures/faints/blackouts	**Yes**	**No**	Please detail if yes
Hearing/vision difficulties	**Yes**	**No**	Please detail if yes
Any hospitalisations?	**Yes**	**No**	Please detail if yes

What are your reasons for seeking an ASD assessment?

Employment Background

Job Title	Name of Workplace	Date from	Date to	Reason for leaving (if applicable)	Any additional support in place in the workplace

Family Background

	Name	Date of Birth	Employment/ Occupation	Title (Mr/Mrs/ Miss/ Ms/ Dr/Mx etc.)	Details of any developmental difficulties (e.g., Autism, ADHD, speech delay, dyslexia, or mental health difficulties)
Biological Mother					
Biological Father					

Are your biological parents together, separated / divorced? If separated/ divorced, what age were you when this occurred and did you maintain contact with your parent(s)?

Who were your primary caregivers as a child?

	Name of Sibling	Date of Birth	Age	Sex	Relationship (e.g., full sibling, adoptive sibling, half sibling)	Details of any developmental difficulties (e.g., Autism, ADHD, speech delay, dyslexia, mental health difficulties)
1.						
2.						
3.						

Extended family – do you have extended family support? Did you have extended family support as a child?

Extended family – do any members if you extended family have any mental health or neurodevelopmental conditions?

Education and Schooling

Please provide as much information as possible about toddler groups, nurseries, schools, and further education:

	Name of nursery/ school/ college/ university	**Type of school** (e.g., mainstream, independent, special school)	**Age when attended**		**Additional support?** If yes, please provide details	**Grades Achieved** (e.g. GCSEs)
			From Years/Months	**From Years/Months**		
1.						
2.						
3.						
4.						

Did you ever received an Individual Education Plan (IEP), Statement of Special Educational Needs (SEN), or Education Health Care Plan (EHCP)?	**Yes**	**No**

Age when Statemented (Years, Months)	

Details of statement (e.g., hours per week, focus of support):	

Where there any concerns about you in relation to schooling
e.g. attendance problems; difficulties coping with school? Please detail below.

Did your teachers express any concerns?

Pregnancy and Birth

If possible, please complete the rest of the questionnaire with a parent and/or family member.

Was there any fertility treatment or support in your conception?	**Yes**	**No**
Were there any complications during pregnancy (e.g., any infections/viral illnesses/ hospital admissions/other)? If yes, please provide details:	**Yes**	**No**

Were any medications taken during pregnancy?
If yes, please provide details on the medication, dose, frequency, and during which trimester:

Name of medication	**Dose**	**Which trimester(s)?** Trimester 1 (1-12 weeks) Trimester 2 (13-26 weeks) Trimester 3 (27 - end of pregnancy)	**Any other details**

Did the mother of the child do any of the following activities during pregnancy?

	Trimester 1 (1 – 12 weeks)		**Trimester 2** (13 – 26 weeks)		**Trimester 3** (27 weeks – end of pregnancy)	
Alcohol	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Please provide details (e.g., frequency & amount):						
Tobacco Products	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Please provide details (e.g., frequency & amount):						
Recreational Drugs	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Please provide details (e.g., frequency & amount):						

Maternal Age	**Age of mother at time of birth:**	**Years**
Paternal Age	**Age of father at time of birth:**	**Years**
Gestation	**When did the mother of the child go into labour?**	**Weeks**

Delivery and Newborn (Please provide details in box)

How were you delivered? Vaginal (forceps or vacuum needed) / C-Sectional (planned / emergency). Please detail below and reason for this delivery method:

Birth Weight (What was the child's weight at birth?)

Any complications during or immediately following birth? If yes, please provide details:

Newborn period: (Did the baby have any major problems in the newborn period (0-30 days of life)?

Your First Year of Life

How would your parents/caregivers have described you during your first year of life?

Feeding: Breast / bottle. Any comments or difficulties?

Sleeping: Sleep patterns. Any comments or difficulties?

Early communication: Eye contact / look at you, smile in response, turn to if you spoke?

Interaction: Seek your attention / want to be held or cuddled / enjoy baby games?

Attachment and bonding: Developing a relationship between baby and parent?

Overview: Did you have any concerns in the first year of your child's life?

Developmental Milestones

Crawling:	**Yes**	**No**	Age		Any Concerns	
Walking unaided:	**Yes**	**No**	Age		Any Concerns	
Bladder control (daytime)	**Yes**	**No**	Age		Any Concerns	
Bladder control (night-time)	**Yes**	**No**	Age		Any Concerns	

Language	Did they babble?		Age of first words:		Age of first phrases (2-3 words together):	
	Yes	**No**				

Have you ever lost of any of the above skills? (If yes, please give details)	**Yes**	**No**

Overall, where there any concerns regarding your developmental milestones?

Overall, how old were you when differences were first noticed? And what were they?

Additional Information

How do you manage activities of daily living (e.g. personal hygiene, dressing, cooking etc.)? do you have any difficulties with these?

Do you initiate and maintain conversation with familiar and/or unfamiliar people? Do you engage in social chit chat (small talk)?

Do you have friendships?
Do you feel you can maintain friendships over time?

Do you have any interests? Do you feel they differ from other people's interests and if so, how?

How do you manage change?
(e.g. if plans change or are cancelled)

Do you have any sensory interests or aversions?
(sight, touch, smell, noise, taste)

Thank you very much for taking the time to complete this questionnaire.