

Attachment 8.h.

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

| <b>Complementary or alternative therapies ever used to treat behavioral symptoms</b> | <b>NO/<br/>DON'T<br/>KNOW</b> | <b>YES</b>               | <b>Age when first used<br/>(specify years and months)</b> | <b>Is child still receiving treatment?</b> | <b>IF NO:<br/>Age when last used<br/>(specify years and months)</b> | <b>If EVER used,<br/>Specify type of therapy or diet</b> |
|--------------------------------------------------------------------------------------|-------------------------------|--------------------------|-----------------------------------------------------------|--------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|
| Chelation therapy                                                                    | <input type="checkbox"/>      | <input type="checkbox"/> | ____ years & ____ months                                  | Yes    No                                  | ____ years & ____ months                                            |                                                          |
| Chiropractic Care or massage therapy                                                 | <input type="checkbox"/>      | <input type="checkbox"/> | ____ years & ____ months                                  | Yes    No                                  | ____ years & ____ months                                            |                                                          |
| Diet: Gluten and/or Casein Free                                                      | <input type="checkbox"/>      | <input type="checkbox"/> | ____ years & ____ months                                  | Yes    No                                  | ____ years & ____ months                                            |                                                          |
| Diet: Yeast Free Diet                                                                | <input type="checkbox"/>      | <input type="checkbox"/> | ____ years & ____ months                                  | Yes    No                                  | ____ years & ____ months                                            |                                                          |
| Diet: Other                                                                          | <input type="checkbox"/>      | <input type="checkbox"/> | ____ years & ____ months                                  | Yes    No                                  | ____ years & ____ months                                            |                                                          |
| Dietary or Vitamin Supplements                                                       | <input type="checkbox"/>      | <input type="checkbox"/> | ____ years & ____ months                                  | Yes    No                                  | ____ years & ____ months                                            |                                                          |
| Herbal supplements, medication or tea                                                | <input type="checkbox"/>      | <input type="checkbox"/> | ____ years & ____ months                                  | Yes    No                                  | ____ years & ____ months                                            |                                                          |
| Hyperbaric Oxygen Therapy                                                            | <input type="checkbox"/>      | <input type="checkbox"/> | ____ years & ____ months                                  | Yes    No                                  | ____ years & ____ months                                            |                                                          |
| Immune treatments (e.g. stem cell transplants or antibiotic or antiviral therapies)  | <input type="checkbox"/>      | <input type="checkbox"/> | ____ years & ____ months                                  | Yes    No                                  | ____ years & ____ months                                            |                                                          |
| Other: specify: _____                                                                | <input type="checkbox"/>      | <input type="checkbox"/> | ____ years & ____ months                                  | Yes    No                                  | ____ years & ____ months                                            |                                                          |
| Other: specify: _____                                                                | <input type="checkbox"/>      | <input type="checkbox"/> | ____ years & ____ months                                  | Yes    No                                  | ____ years & ____ months                                            |                                                          |
| Other: specify: _____                                                                | <input type="checkbox"/>      | <input type="checkbox"/> | ____ years & ____ months                                  | Yes    No                                  | ____ years & ____ months                                            |                                                          |

| <b>Medications ever used to treat behavioral symptoms</b> | <b>NO/<br/>DON'T<br/>KNOW</b> | <b>YES</b> | <b>Age at first dose<br/>(specify years and months)</b> | <b>Is child still receiving medication?</b> | <b>IF NO:<br/>Age at last dose<br/>(specify years and months)</b> | <b>If EVER used,<br/>Specific name(s) of medication(s)</b> |
|-----------------------------------------------------------|-------------------------------|------------|---------------------------------------------------------|---------------------------------------------|-------------------------------------------------------------------|------------------------------------------------------------|
|                                                           |                               |            |                                                         |                                             |                                                                   |                                                            |

|                                                                                                     |                          |                          |                         |           |                         |  |
|-----------------------------------------------------------------------------------------------------|--------------------------|--------------------------|-------------------------|-----------|-------------------------|--|
| Antidepressants, anti-anxiety, or obsessive-compulsive medications, such as Prozac or Zoloft        | <input type="checkbox"/> | <input type="checkbox"/> | ____years & ____ months | Yes    No | ____years & ____ months |  |
| Atypical Antipsychotics, such as Risperdal or Abilify                                               | <input type="checkbox"/> | <input type="checkbox"/> | ____years & ____ months | Yes    No | ____years & ____ months |  |
| Medications used to treat seizures and/or stabilize mood, such as Tegretol, Lamictal                | <input type="checkbox"/> | <input type="checkbox"/> | ____years & ____ months | Yes    No | ____years & ____ months |  |
| Non-stimulant medications used to treat hyperactivity or inattention, such as Tenex or Clonidine    | <input type="checkbox"/> | <input type="checkbox"/> | ____years & ____ months | Yes    No | ____years & ____ months |  |
| Stimulant medications often used to treat hyperactivity or inattention, such as Ritalin or Adderall | <input type="checkbox"/> | <input type="checkbox"/> | ____years & ____ months | Yes    No | ____years & ____ months |  |
| Other medication                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | ____years & ____ months | Yes    No | ____years & ____ months |  |
| Other medication                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | ____years & ____ months | Yes    No | ____years & ____ months |  |
| Other medication                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | ____years & ____ months | Yes    No | ____years & ____ months |  |
| Other medication                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | ____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 bupropion.)
- 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 methylphenidate.)
- 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.)

