

Questionnaire Type II

*** This questionnaire is for kids over 60 months of age who are fluent in language and have good cognitive abilities, but lack only social skills**

Thank you for visiting the Dr. Tomato Website. This is required to fill out in advance to minimize discomfort during consultation and to provide prompt and personalized treatment plan.

1. Personal Information

Name		SSN No.			
Height / Weight	ft/ lb	Age	Years m	Gender	F. M
Address					
Phone no. Email.	Primary	Secondary			
Parents Occupation	Father	Mother			

2. How did you find the Dr. Tomato Website/Protocol (Please select)?

- ① If you are introduced by a person/family who has experienced or knows Dr. Tomato, please name or indicate relation, if possible _____
- ② Word of mouth ③ Internet search (search engine: _____)
- ④ Other: (_____)

3. General Question

1) Does your child have any other health condition(s) other than developmental issues? (e.g. epilepsy)?

2) If your child was diagnosed or evaluated at a hospital, please provide the name of the hospital: (_____) and
Diagnosis received (_____)

3) Is your child currently taking any medications? (including herbal medicines) (e.g. anticonvulsants).

4) Please write the name of the institution your child is currently treating, the type of treatment, and the treatment period (months).
(Example: 00 Hospital, physical therapy, Bobath, occupational therapy, speech therapy, sensory integration therapy)

5) If you have observed any effect(s) from any of the treatment(s) received, please write them in detail and their effect(s).

6) Is your child currently attending or has ever participated in an educational institution? If yes, please indicate institution (e.g. daycare, preschool etc.) and frequency (times a week, hours per day)

4. Questions about Child Development

1) Delivery time : Pregnancy () Term () Your child's weight at birth (lb)
/ Incubator duration: (days)

2) Were there any abnormalities that could affect your child's brain function before, during, or shortly after birth? (e.g. neonatal cerebral hemorrhage, hypoxia, chromosomal abnormalities). If yes, please write.

3) How old was the mother and father when your child was born? Was there any illnesses both parents may have experienced during the pregnancy/child birthing period.

Mother's age at birth () Father's age at birth ()

Mother or father's specific medical condition during pregnancy/birth, if any ()

4) Has your child ever been cared by a guardian other than the parent? If yes, what is the relationship like?

5. Developmental History

1) Please describe below indicated developmental status when he/she was around 12 months old.

- How much language did your child produce? Please write exact words, if any except babbling.
- Was it possible to imitate others such as saying "hi" and waving or saying "bye,bye" or peak-a-boo? If possible, please indicate.
- Has there ever been times your child has shown happiness or excitement when a parent has returned home from work? (If there has been an emotional interaction please write in detail).
- Please describe his/her eye contact and response to name.

2) Please describe followings when the child was around 24 months of age.

- Language :
- Behavior imitation :
- Eye contact :
- Response to Name :
- Social Interaction :

3) What was your child's first word? What age was it spoken?

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4) When did your child start walking?

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5) Please tell us whether you think that your child's development was slow from the beginning or if you think it was delayed at some point during normal development.

6) If you believe that your child's development was delayed at a later age and not from birth, please tell us since when it was, and any specific cause you have in your mind.

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6. Current State of Development

1) What are your thoughts on your child's developmental issues? (e.g. autism, Asperger syndrome, language delay).

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2) Please indicate at what age do you think your child's current social development is?

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3) Please indicate how much you think your child's developmental state is behind his or her age.

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4) If there is an abnormality in child's spontaneous language habits, please indicate in detail. (e.g. echo, high pitch voice, stuttering, instability in pronunciation, word expression of out of situation, scripting, repeating same words, etc.).

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5) How many circles you can make with back and forth communication with your child? What is the main reason that a conversation may stop and not have a back and forth type flow?

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6) What is the level of your child's academic comprehension ability? Please describe using specific figures, if available.

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Comprehension – high, medium, low

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Academic Performance Level – within ____ %.

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7) Does your child have friends on their own without family support? How many close friend does your child have? Briefly describe characteristics of these friends (For example, a friend from school, the play well together and play games such as..., this friend has a gentle, kind personality etc.)

8) What do you think the biggest issue is that prevents to develop social skills?

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9) Please describe in detail if your child experiences any difficulties in academic performance and/or extracurricular activities.

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10) Please describe in detail if your child has ever faced a frustrated situation like being blamed or treated unfairly by a peer, teacher or mates at school or during extracurricular activities.

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11) Please indicate about your child's eye contact.

- Selectively make eye contact only when he/she wants to. ()
- Eye contact is very short. ()
- Makes good eye contact with family, but not stable with other people. ()
- Rarely make eye contact. ()
- Makes eye contact, but cannot convey subtle emotions. ()
- Have normal eye contact. ()

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12) Please describe in detail if there is specific stereotyped behavior or sensory-seeking behavior.

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13) Please describe any special talents/gift or characteristics your child has.

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14) If your child has any psychological issue, such as anxiety disorder, obsessive-compulsive disorder, sleep disorder, difficulty in anger control, please describe in detail.

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7. Questions for Treatment Plan

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1) Please tell us what you are thinking of about specific treatment goals for your child.

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A. ADHD Evaluation

Questions	Not at all (0)	Occasionally (1)	Often (2)	Very Often (3)
1. My child makes mistakes while performing a task due to carelessness or poor concentration.				
2. There are instances where my child finds it difficult to maintain concentration during class or playtime.				
3. My child does not listen when people talk around or to him/her.				
4. My child finds it difficult to follow instructions and fails to complete tasks such as homework and assignments.				
5. My child has difficulty doing tasks or activities systematically.				
6. My child avoids, dislikes, or resists continuous engagement in tasks that require mental strength.				
7. My child often loses items that are required for tasks. (E.g. toys, homework, pencils, books etc.)				
8. My child is often distracted by external stimuli.				
9. My child often forgets about daily tasks/activities.				
❖ Total point score from questions 1-9:				
10. My child does not stay still. His/her hands and feet are moving constantly and he/she is usually wriggling while sitting down.				
11. My child often gets up and out of their seat in class or during times when they are supposed to stay seated.				
12. My child moves around a lot and likes to climb things.				
13. My child finds it difficult to play calmly and keep their concentration while playing.				
14. My child is constantly moving around as if they have a motor.				
15. My child has a tendency to talk a lot.				

16. My child often tries to answer questions or talk suddenly before the question has been asked.				
17. My child often cannot wait for their turn in something.				
18. My child often interrupts other people or interferes with things they are not meant to (E.g. interrupts a conversation or interferes in another child's play/game).				
19. He/she often abruptly answers the question before the question is finished.				
❖ Total point score from questions 10-19:				
Total Score:				

A1. Are the above behavioral problems observed at home and school, kindergarten, daycare () or observed only at home () or observed in all places ()

Please describe the above: _____

A2. From what age did the behavior problems begin to appear and how did it appear (please describe): _____

Starting age ()

B. Evaluation of Emotional and Behavioral Disorders

Questions	Not at all (0)	Occasionally (1)	Often (2)	Very Often (3)
A. My child's level of intelligence is normal but learning results are extremely low.				
B. My child displays a negative attitude towards interpersonal relationships (e.g. friends and teachers).				
C. My child exhibits inappropriate behaviors or emotions in normal and everyday situations.				
D. My child lives in a constant state of anxiety and/or depression.				
E. My child feels abnormal physical pain and/or fear due to emotional anxiety.				
F. My child experiences difficulty with interpersonal relationships due to visual, auditory and tactile related problems.				
❖ Total point score (A-F):				
Questions	Not at all (0)	Occasionally (1)	Often (2)	Very Often (3)
G. My child is often aggressive, destructive and disobedient.				
H. My child has no sense of responsibility and often complains or blames others for their actions.				
I. My child lacks social confidence and often feels unsure in social situations.				
J. My child often displays neurotic symptoms and often fears and worries.				
K. My child is careless and easily distracted.				
L. My child exhibits bad habits in daily life and learning. They have a tendency to be careless and want to quit what they are doing.				

M. My child exhibits cognitive deficits in reasoning and understanding. They cognitive development is/seems delayed.				
N. My child requires external/extra help outside him/herself in activities of daily living and learning performance, due to poor intellectual ability.				
O. He/she often abruptly answers the question before the question is finished.				
❖ Total point score (G-O):				

B1. From what age did the problematic behavior (relating to the above questions) appear? Age ()

Please describe the behavior observed: _____

B2. If your child has taken any medication for any conditions, please list what medication was taken and why.

B3. How long was the medication taken for? _____

B4. Please explain if your child had any adverse reactions to any of the medications:

< C. Questions for herbal medicine and nutritional supplement prescription >

C1. If your child has sleep problems, please indicate in detail.

- Does your child not get a deep sleep and wake up frequently? ()
- Does your child often wake up and cry? ()
- Does your child wake up from sleep and spend the night playing for a while? ()
- Does your child have difficulty falling asleep and toss and turn for a long time? ()
- If there are any other abnormalities in sleep, please write in detail.
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C2. If there is an abnormality in the stool, please indicate in detail.

- How often does your child defecate? (Example: Once every 2 days) - ()
- Does the stool tend to be soft? Is it a strong tendency? ()
- Is the stool prone to constipation? Or is it a tendency to diarrhea? ()
- Does the stool or fart smell bad? ()
- Do you often see undigested grains or food from child's stool? ()
- Does your child occasionally scratch because of itching around the anus? ()
- Does your child often complain of abdominal pain?
- If there are any other abnormalities in the stool, please write in detail.
()

C3. If there is an abnormality in child's skin such as atopic dermatitis, hives, or skin rash, please indicate in detail.

- If atopy occurs frequently, the affected area is (e.g. around the neck) ()
- If hives occur frequently, the affected area is ()
- In case of frequent rashes and papules on the skin, the affected area is ()
- Is your child's skin color white or black? ()
- Is your child's skin glowing? Or is it dry? ()
- If there are any other skin abnormalities, please write in detail.
()

C4. If there are any abnormalities in your child's emotional state, please indicate in detail.

- Is your child timid and often feels anxious and fearful? ()
- Is your child easily annoyed? ()
- Does your child have difficulties in daily life due to extreme distraction? ()
- Does your child get overly excited or show uncontrollable hyperactivity repeatedly? ()
- Does your child often shows sudden laughing or sudden crying on his/her own? ()
- Does your child often shows a dazed state, such as staring blankly into the air. ()
- please write in detail if there is any other abnormal emotional state you have noticed.
()

C5. If there are any abnormalities in the child's nutrition or growth, please write down in detail.

Is your child's height or weight below average? If yes, please write in detail.

Height (height) - ()

weight (weight) - ()

Appetite state -

C6. Please indicate child's general pattern of infection.

Colds – Does your child often catch colds? What are the initial symptoms of a cold?

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Rhinitis – Does your child have allergic rhinitis, often shows stuffy nose or runny nose?

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Conjunctivitis - Does the symptom of conjunctivitis recur in spring or autumn?

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Bad breath - Does your child have bad breath?

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C7. Describe any abnormalities or characteristics of the child's health that the physician should

be aware of during treatment.

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I hereby certify that as the parent /guardian of _____, have completed this questionnaire.

Date:

Name of Parent /Guardian _____

Signature _____



Dr. TOMATO
KIMS AUTISM