Carolina Institute for Developmental Disabilities
Angelman Syndrome Clinic Questionnaire

Return completed questionnaire, diagnostic genetics report, and any additional information to:

Twyla Peoples, Clinical Coordinator
Carolina Institute forDevelopmental Disabilities
101 Renee Lynne Ct., Carrboro, NC 27510
Telephone: (919) 966-5171; Fax: (919) 966-2230

Please fill out this questionnaire in black or blue ink as completely as possible. Please Print.

Child's Name_____ **Birthdate**_____
Last First MI

Gender_____ Race/Ethnicity_____

Name of Person(s) Completing Questionnaire_____ Date Completed_____

Relationship to Child _____

Address_____

Phone Number _____ Email_____

Date of AS diagnosis_____ Age at time of AS diagnosis_____

Etiology (*circle one*): UPD Deletion (class 1 / 2) Imprinting center deficit UBE3A mutation Other

Where and by Whom was the diagnosis made_____

PLEASE ATTACH A COPY OF THE DIAGNOSTIC GENETIC REPORT

CIDD AS clinic offers comprehensive services with up to seven professional disciplines available. However, the full comprehensive clinic has a very long wait list. It is possible to be seen sooner if fewer professionals are needed. In order to streamline our services for you and your loved one, please rank your top three priority needs.

Seizure Management

Behavior Management

Genetic Counseling

Communication

Developmental/Learning Ideas

Physical Therapy Consultation

Occupational Therapy Consultation

Sleep Issues

Family Support/Social Work

OR

I would like a comprehensive assessment with all professional disciplines ☐

I would be available to attend the clinic on short notice. Please contact me in the event of a cancellation or other appointment opening. ☐ **Yes** ☐ **No**

I. Family Information

Mother's full name: _____
Mothers's Highest school grade completed_____ Mother's Place of employment:_____
Mother's Job/Title:_____

Father's full name: _____
Father's Highest school grade completed_____ Father's Place of employment:_____
Father's Job/Title:_____

With whom does your child live? Please check all that apply.
_____Biological parent(s) _____Adoptive parent(s) _____Foster parent(s)

_____Mother only _____Father only _____Grandparent(s)

_____Parent and Step-parent _____Parent and Domestic Partner _____

Residential/Group Home_____Other (specify):_____

Please provide the age and relationship to the child for each person who currently lives in the same home with your child with AS

Age	Relationship to Child

Family's annual income: _____under $10,000 _____$10,000 to $14,999 _____$15,000 to $24,999
_____$25,000 to $34,999 _____$35,000 to $49,000 _____$50,000 to 74,999 _____Over $75,000

FAMILY HISTORY:

Note below if any of your child's **biological ("blood")** relatives have had any of the following conditions:

Condition	Siblings (include half siblings)	Father	Father's Family	Mother	Mother's Family
Autism/ PDD					
Convulsions/Seizures					
Neurologic Disorders					
Aggressive/Violent Behavior					
Alcoholism/Substance Abuse					
Depression					
Anxiety					
Other					

II. Child's Medical Information

Birth weight:_____ Birth Length: _____Total number of weeks of pregnancy: _____

How was your baby delivered: _____vaginally _____by Caesarean section

What were your first impressions of your baby? _____

_____

Check any of the following that your child had in the first month of life:

_____Breathing problems _____Convulsions _____Skin rash
_____Jaundice (yellow) _____Infection _____Deformity
_____Excessive crying _____Injury _____Feeding difficulty Other:_____

Has your child ever been seriously ill? _____ With what? _____

Has your child had any serious injuries? _____ What kind? _____

Is your child currently on medication? ____ *If "yes," please indicate:*

Medicine	Dates taken	Dosage	Reason prescribed

Do you have any current medical concerns? _____ *If "yes" please explain* _____

_____

_____

Does your child have a history of seizures? Y N

Age of Onset_____

How often does he/she have a seizure_____

III. Developmental History

PHYSICAL SKILLS:

At what age did your child? *(Write "not yet" when appropriate.)*

_____roll over _____sit without support _____crawl _____pull to standing _____walk alone

_____eat with a spoon _____copy printed letters _____bladder train _____bowel train

_____climb stairs _____ride a tricycle _____run _____skip _____ride a bicycle

What concerns do you have about your child's physical / motor development? _____

_____

Has your child lost a previous skill?_____ *If yes, please explain:*_____

COMMUNICATION AND HEARING:

How is your child's hearing? _____good _____poor _____none _____inconsistent _____uncertain

Child's main communication methods: ____gestures ____crying ____noises/sounds ____words ____AAC system

At what age did your child? *(Write "not yet" when appropriate.)*

_____make single sounds _____use single words _____combine words in short phrases

Did your child begin to use words and then stop? ___Yes ___No *If "yes," at what age?*_____

What are your primary communication concerns? _____

_____

_____

IV. School/ Services Information

Is your child currently in school, preschool, or daycare? **Y N** If yes, where?_____

Current/highest grade completed _____ Special Education Category _____

Is your child currentlyreceiving therapy services? ___Yes ___No *If "yes," please indicate:*

Service	School Based	Hrs/Week	Private	Hrs/Week
Occupational Therapy				
Physical Therapy				
Speech & Language Therapy				
Behavior Therapy				
Other:				

If not in school, does your child participate in a day or work program? **Y N** *If yes, please describe:*

_____

Does your child participate in any recreation / leisure activities? **Y N** *If yes, please describe:* _____

_____

V. Behavior Information

Do you, or anyone else, have any concerns with your child's behavior? ___Yes ___No *If "yes," please describe:* _____

_____

Who generally disciplines your child? _____

What methods are used? _____

How successful are the discipline methods? _____

_____

Does your child have behavioral tantrums (outbursts)? ___Yes ___No *If "yes," please circle the response that best describes the frequency and severity of characterisitics of your childs tantrums:*

(0) not a problem	**(1) mild problem**	**(2) moderate problem**	**(3) severe problem**
1. Biting	0	1	2	3
2. Kicking	0	1	2	3
3. Screaming	0	1	2	3
4. Whining	0	1	2	3
5. Throwing objects	0	1	2	3
6. Hitting	0	1	2	3
7. Other:	0	1	2	3

What causes these behavioral outburst? _____

_____

_____

Does your child have a preference for one cargiver (over others)? ___Yes ___No *If "yes," please explain:*

_____

_____

_____

Does your child display agitation upon someone coming between them and their preferred caregiver?

___Yes ___No *If "yes," please explain:* _____

_____

_____

Does your child display agitation if the preferred caregiver attends to someone else or attempts to leave your child for any amount of time? ___Yes ___No *If "yes," please explain:* _____

_____

_____

Does the preferred caregiver expierence anxiety/fear when leaving the child? ___Yes ___No *If "yes," please explain:* _____

_____

_____

Does your child display agitation upon breaking gaze (eye contact) with the preferred caregiver?

___Yes ___No *If "yes," please explain:* _____

_____

_____

VI. Family and Community Supports

What are your child's strengths?

_____
_____
_____

What are your child's interests?

_____
_____
_____

What are your family's strengths?

_____
_____
_____

What are the current stressors (e.g., marital, parenting, lack of support, financial) in your family?

_____
_____
_____

Does your child receive Social Security Disability? YES NO

Does your child have Medicaid? YES NO

Does your child have the Innovations Waiver (NC Residents) YES NO

What supports is your child receiving (e.g., respite, in-home skill building, skilled nursing care, community networker, etc.)?

_____
_____
_____

What supports are other family members receiving (e.g., family support, faith-based community, other community support groups, sibling groups, individual or family therapy)?

_____
_____
_____

What questions do you have for the CIDD Social Worker/what supports do you need?

_____
_____