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 for Developmental 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 ________________

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

CI DD 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 Developmental/Learning Ideas
Behavior Management Physical Therapy Consultation
Genetic Counseling Occupational Therapy Consultation
Communication 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

<table>
<thead>
<tr>
<th>Age</th>
<th>Relationship to Child</th>
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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:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Siblings (include half siblings)</th>
<th>Father</th>
<th>Father’s Family</th>
<th>Mother</th>
<th>Mother’s Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism/ PDD</td>
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<tr>
<td>Convulsions/Seizures</td>
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<td>Neurologic Disorders</td>
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<td>Aggressive/Violent Behavior</td>
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<td>Alcoholism/Substance Abuse</td>
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<td>Depression</td>
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<td>Anxiety</td>
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<td>Other</td>
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</table>
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:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dates taken</th>
<th>Dosage</th>
<th>Reason prescribed</th>
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</table>

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 currently receiving therapy services?  ___Yes  ___No  If “yes,” please indicate:

<table>
<thead>
<tr>
<th>Service</th>
<th>School Based</th>
<th>Hrs/Week</th>
<th>Private</th>
<th>Hrs/Week</th>
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<tbody>
<tr>
<td>Occupational Therapy</td>
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<tr>
<td>Physical Therapy</td>
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<tr>
<td>Speech &amp; Language Therapy</td>
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<tr>
<td>Behavior Therapy</td>
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<tr>
<td>Other:</td>
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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 characteristics of your child’s 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 outbursts? ______________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Does your child have a preference for one caregiver (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 experience 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?
______________________________________________________________________________________________
______________________________________________________________________________________________