QST INTAKE QUESTIONNAIRE

<table>
<tr><td>Child's name :</td><td>DOB:</td></tr>
<tr><td colspan="2">Referred by:</td></tr>
<tr><td colspan="2">Today's Date:</td></tr>
<tr><td colspan="2">Person completing form/relationship to child:
Phone:</td></tr>
<tr><td>Parent's name:

Email address:</td><td>Home phone:
Cell phone:
Work phone:</td></tr>
<tr><td>Parent's name:

Email address:</td><td>Home phone:
Cell phone:
Work phone:</td></tr>
<tr><td>Sibling's names:</td><td>Ages:</td></tr>
<tr><td colspan="2">Other household members:
Relationship to child:</td></tr>
<tr><td colspan="2">ELIGIBILITY SCREENING FOR THE CHILD:</td></tr>
<tr><td colspan="2">Is there a diagnosis?
Medical or educational?</td></tr>
<tr><td colspan="2">Does your child have sensory problems?</td></tr>
<tr><td colspan="2">Are there other medical problems? Please list:</td></tr>
<tr><td colspan="2">Is your child taking medication or dietary supplements? Please list medications/supplements:</td></tr>
<tr><td colspan="2">Are intensive medical/behavioral treatments planned during the QST? (e.g. chelation, ABA therapy).</td></tr>
<tr><td colspan="2">ELIGIBILITY SCREENING FOR PARENTS:</td></tr>
<tr><td colspan="2">Parents must be ready, willing and able to transport your child to the clinic twice a week, a total of 21 times in all over the five months of training. Are you able to do that?</td></tr>
<tr><td colspan="2">How many parents/other adults will be trained to give the massage?</td></tr>
<tr><td colspan="2">Parents must be willing and able to give their child about 15 minutes a day of Qigong massage at least once a day. Can you agree to do this?</td></tr>
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Who would be giving your child the treatment?
Your child will be tested before and after the training. Are you willing to fill out the parent questionnaires?
What other treatment will your child be receiving while the QST is going on (e.g., OT, speech therapy)?
ELIGIBILITY SUMMARY CHECKLIST
☐ 6 years of age or younger ☐ Presence of sensory impairment ☐ Educational or medical diagnosis of Autism Spectrum Disorder ☐ Little or no medication ☐ No current intensive medical or behavioral interventions ☐ Parent committed to giving daily Qigong massage
PARENT/CHILD HISTORY:
Anything unusual in the pregnancy? *(please circle)* **Yes** **No**
Date of birth:
Birth order (e.g. first born, second born): Birth weight:
Was there anything unusual about the birth? **Yes** **No** If yes, please describe:
Would you say that it was a difficult delivery? **Yes** **No** If yes, what was difficult?
Did your child receive all of his/her immunizations on schedule? **Yes** **No** If not, what was different?
Do you remember your child having reactions to their immunizations? **Yes** **No** Please describe the reactions:
Describe your child's overall health and use of medication during the first years of life (frequent ear infections, asthma, skin conditions, seizures):
Did your child have any hospitalizations or surgeries? **Yes** **No** List each occurrence and at what age they occurred:

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How old was your child when you first noticed the autism? What was the first thing you noticed?
Is your child on a special diet? Please describe:
Describe the variety of food your child eats (e.g. very few foods, , picky eater/somewhat limited, similar to the rest of the family)
Does your child understand simple words and directions?
How much speech does your child have now? (none, a few words, simple sentences, a lot)
PARENT CONCERNS
What is your dream for your child in the next year?
What are your concerns about your child in these areas: 1. Sleep – 2. Digestion – 3. Diet – 4. Self-soothing – 5. Attention/Eye Contact – 6. Speech/language – 7. Social – 8. Difficult Behavior – 9. Other –
What three things would you most like to see change with your child during the next few months? 1. 2. 3.

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