



Autism Needs Survey

In an effort to identify community needs and resources, we would appreciate your help by completing this survey. This survey is being conducted by **the Virginia Autism Action Groups and Commonwealth Autism Service**.

For parents: Throughout the survey, the individual with an Autism Spectrum Disorder is referred to as “your child”, we acknowledge that your child may be of any age. If you have more than one child with Autism Spectrum Disorder, please complete the survey for the oldest child. For Professionals: Please complete this survey based on your experience and input from your clients.

Autism Spectrum Disorders are classified as pervasive developmental disorders (PDDs) and include: Autism, Childhood Disintegrative Disorder, Rett’s Syndrome, Asperger’s Syndrome, and Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS).

Please respond to each question. If the question does not pertain to you, simply skip that question. Your participation is completely voluntary. Your responses are anonymous, meaning your name does not appear on this survey and is not associated with any responses. You do not have to answer any questions that you do not want to answer.

Please return the survey to:
Didi Zaryczny
Commonwealth Autism Service
403 Otey Street
Bedford, VA 24523
dzaryczny@autismva.org

Thank you again for your time and feedback. The information you provide is vital to improving services for people with Autism Spectrum Disorders in the Commonwealth of Virginia.

Sincerely,
Didi Zaryczny

I. General Information

I am a:

- Individual with a Disability
- Parent/Guardian of an Adult with a Disability
- Parent/Guardian of a Minor Child with a Disability
- Family Member (other than a parent) of an Individual with a Disability
Relationship: _____
- Teacher/Educational Professional
- Medical Professional
- Mental Health Professional or Other Service Provider
- Other: _____

II. Residency

1. How long have you lived in your current locality?
___ years
___ months
2. In what county do you currently reside? _____

III. General Information About Child

1. How old is your child?
_____ years
_____ months
2. What is your child's gender?
___ Male
___ Female
3. What level of education has your child completed?
___ None
___ Preschool
___ Kindergarten
___ Elementary School (specify highest grade completed _____)
___ Middle School (specify highest grade completed _____)
___ High School (specify highest grade completed _____)

- College
- Graduate School
- Home schooling (specify highest grade completed _____)

IV. General Information on Diagnosis and Professional Services

4. What is your child's current diagnosis?
 - Autism Disorder
 - Asperger's Disorder
 - Childhood Disintegrative Disorder
 - Rett's Syndrome
 - Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS)
 - Other (please specify _____)

5. How old was your child when he/she got the diagnosis?
 - years
 - months

6. Have any of the child's siblings been diagnosed with Autism Spectrum Disorder?
 - yes (if yes, please specify which disorder: _____)
 - no

7. Does your child have other symptoms or diagnoses? (check all that apply)
 - Anxiety Disorder
 - Attention Deficit Hyperactive Disorder (ADHD)
 - Obsessive Compulsive Disorder
 - Central Auditory Processing Disorder
 - Depression
 - Schizophrenia
 - Hearing Impairment
 - Vision Impairment
 - 'Tunnel Vision Syndrome' (peripheral vision, vision perception impairment)
 - Mental Retardation
 - Seizures
 - Dietary allergies (please specify _____)
 - Digestive Problems (constipation, diarrhea, bloating, or abdominal pain)
 - None
 - Other (please specify _____)

8. What type of professional diagnosed your child with Autism Spectrum Disorder?
 - Developmental Pediatrician
 - Psychologist
 - Neurologist
 - Primary Care Physician
 - Psychiatrist

___ Other (please specify _____)

9. What did that professional do after diagnosing your child? Check all that apply.

- ___ Provided no additional information
- ___ Gave you information about available resources
- ___ Gave you literature on Autism
- ___ Spent time talking with you about Autism
- ___ Referred you to an Autism specialist
- ___ Referred you to a support group
- ___ Advised on educational programs
- ___ Advised on medical problems
- ___ Other (please specify _____)

10. When you first received the diagnosis, who/what helped you to learn about Autism Spectrum Disorder?

- ___ Healthcare Professionals
- ___ Education Professionals
- ___ Parent Resource Centers
- ___ Parents of children with Autism
- ___ Family member
- ___ Friends
- ___ Support Groups
- ___ Advocacy groups
- ___ Internet
- ___ Books, Magazines, and Videotapes
- ___ Conferences and Workshops
- ___ I did not seek further information
- ___ Other (please specify _____)

11. Are you a member of a support group or advocacy group for parents?

- ___ Yes, autism specific
- ___ Yes, not autism specific
- ___ Yes, both autism specific and not autism specific
- ___ No, but was a member in the past
- ___ No, have never been a member
- ___ No, but I want to belong to a group.

12. Are any siblings in the home attending a sibling support group?

- ___ yes
- ___ no

13. Have you ever moved to another school district to get better services for your child?

- ___yes
- ___no

V. Current Symptoms Displayed by Child

Please check the symptoms currently exhibited by your child: (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Doesn't respond when called | <input type="checkbox"/> Thrush (white tongue yeast infection) |
| <input type="checkbox"/> Self-injurious behaviors | <input type="checkbox"/> Itchy penis/perineum/all |
| <input type="checkbox"/> Destructive behaviors | <input type="checkbox"/> Losing weight |
| <input type="checkbox"/> Receptive language delay | <input type="checkbox"/> Gaining weight |
| <input type="checkbox"/> Expressive language delay | <input type="checkbox"/> Fixation on objects or topics |
| <input type="checkbox"/> No verbal language | |
| <input type="checkbox"/> Apraxia (oral motor, articulation problems) | <input type="checkbox"/> Unusual cravings for certain foods (please specify: _____) |
| <input type="checkbox"/> Absent or limited gestures | <input type="checkbox"/> Has known food sensitivity (please specify: _____) |
| <input type="checkbox"/> Cognitive delay | |
| <input type="checkbox"/> Strong visual learner | <input type="checkbox"/> Sustained odd play |
| <input type="checkbox"/> Strong auditory learner | <input type="checkbox"/> Echolalia (repeats the same phrase over and over) |
| <input type="checkbox"/> Gross motor delay | <input type="checkbox"/> Does not require long sleep |
| <input type="checkbox"/> Fine motor delay | <input type="checkbox"/> Requires longer than average sleep |
| <input type="checkbox"/> Undersensitive to pain | <input type="checkbox"/> Does not stay asleep |
| <input type="checkbox"/> Oversensitive to pain | <input type="checkbox"/> Wakes up at night and does not go back to sleep |
| <input type="checkbox"/> Undersensitive to sound | <input type="checkbox"/> Takes a long nap daily |
| <input type="checkbox"/> Oversensitive to sound | <input type="checkbox"/> Tantrums |
| <input type="checkbox"/> Aggressive to others | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Has trouble joining a group | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Happier left alone | <input type="checkbox"/> Hand flapping |
| <input type="checkbox"/> Frustrated | <input type="checkbox"/> Toe walking |
| <input type="checkbox"/> Gets angry easily | <input type="checkbox"/> Spinning Self |
| <input type="checkbox"/> Cries excessively | <input type="checkbox"/> Likes to watch object spin |
| <input type="checkbox"/> Hums frequently | <input type="checkbox"/> Rhythmic or rocking behaviors |
| <input type="checkbox"/> Insists on sameness | <input type="checkbox"/> Other types of self-stimulatory behavior (please specify: _____) |
| <input type="checkbox"/> Agitated when routine is disrupted | |
| <input type="checkbox"/> Insists on precision | |
| <input type="checkbox"/> Poor eye contact | |
| <input type="checkbox"/> Stomach pain | |
| <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Eczema | |

This is a list of general services that could be available for children with Autism Spectrum Disorder.

Of these services, place a checkmark in the corresponding column for those you currently use or have used.

Then, **whether or not you have used these services**, please rate your opinion of the following:

1. First, please rate your opinion of the degree to which these services are currently available in the your Region of Virginia Second, please rate your opinion of the general quality of those services. If not available in your region, circle N/A.
2. Third, please rate your opinion of the need/importance for these services to be offered in the your Region of Virginia.

Circle the number that best reflects your opinion, using the following scale.

Very Low **Low** **Moderate** **High** **Very High**
1 **2** **3** **4** **5**

	USING	USED IN PAST	AVAILABILITY					QUALITY					NEED					
			1	2	3	4	5	1	2	3	4	5	N/A	1	2	3	4	5
BEHAVIORAL TREATMENT (such as Applied Behavior Analysis, Pivotal Response Training, Discrete Trial Training, or Positive Behavior Supports)																		
SOCIAL SKILLS TRAINING																		
SPEECH-LANGUAGE THERAPY																		
EARLY INTERVENTION (0-3 YEARS)																		
OCCUPATIONAL THERAPY																		
PLAY THERAPY																		
FLOORTIME/GREENSPAN																		
MUSIC, DANCE, OR DRAMA THERAPY																		
SENSORY INTEGRATION THERAPY																		
PHYSICAL THERAPY																		
VOCATIONAL TRAINING																		
IEP TRAINING																		
POST-SECONDARY TRANSITION TRAINING																		

ANIMAL THERAPY			1 2 3 4 5	1 2 3 4 5 N/A	1 2 3 4 5
DIETARY INTERVENTIONS (such as Casein-free/Gluten-free diets, Fatty acids, Feingold diet, Alkaline shots, Magnesium, or Vitamin supplements)			1 2 3 4 5	1 2 3 4 5 N/A	1 2 3 4 5
RESPITE CARE			1 2 3 4 5	1 2 3 4 5 N/A	1 2 3 4 5
FAMILY SERVICES (such as Family Counseling, Parent Support Group, Sibling Support Group, Parent Advocacy Group, or Parent Training)			1 2 3 4 5	1 2 3 4 5 N/A	1 2 3 4 5
AUTISM SPECIALTY CLINICS/CENTERS			1 2 3 4 5	1 2 3 4 5 N/A	1 2 3 4 5
MEDICATIONS (such as SSRIs, stimulants, or antipsychotics)			1 2 3 4 5	1 2 3 4 5 N/A	1 2 3 4 5
DIAGNOSTIC SERVICES			1 2 3 4 5	1 2 3 4 5 N/A	1 2 3 4 5
EDUCATOR'S TRAINING			1 2 3 4 5	1 2 3 4 5 N/A	1 2 3 4 5
WEB-BASED RESOURCE NETWORK			1 2 3 4 5	1 2 3 4 5 N/A	1 2 3 4 5
SPECIAL NEEDS CAMPS			1 2 3 4 5	1 2 3 4 5 N/A	1 2 3 4 5

Please list the most needed services related to Autism Spectrum Disorders in your region of Virginia..

Thank you for your time and feedback.

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Fax: 540-587-0664