Children's National ™ Date:_____

Overnight EEG Questionnaire

Our goal is to create a positive experience for your child at Children's National. If your child is on the spectrum or has a developmental difference that could interfere with their ability to receive care, fill out the form below. This information helps us learn more about your child's special needs so we can provide the best care possible. Please bring this with you on the day of the visit. You may also send a completed questionnaire **at least 3 days before** the EEG appointment to BeyondtheSpectrum@childrensnational.org or fax to 202-476-3393. For questions, call 202-476-2884.

Child's Procedure Date & Time: _____ Name of doctor: _____

Child's Name: _____ Nickname: _____ Birthdate: _____ Developmental age:_____

Your Name: _____ Relationship: _____ Phone and E-mail:_____

Child's medical and behavioral conditions or diagnoses:_____

Interests

What is your child's favorite (write answers below):

Environment, activities, and arts:

Technology devices, games, and characters:

Songs, music type/musicians:

Toys/Fidgets:

Rewards/motivators:

Food/snacks:

Communication

How does your child communicate wants and needs (mark all that apply)?

☐ Talks or Uses words
☐ Pictures or symbols
☐ Written or typed words
☐ Gestures or points
☐ Makes sounds
☐ Facial expressions
☐ Communication Device
☐ American Sign Language
☐ Other _____

How does your child learn new information (mark all that apply)?

☐ Pictures with words
☐ Pictures without words
☐ Communication device
☐ Short simple phrases
☐ Time to process information
☐ Typed or written words
☐ Social stories
☐ First, Then Board
☐ Other:_____

How does your child know time is passing (mark all that apply)?

☐ Clock/watch
☐ Schedule boards
☐ Length of song or video
☐ Timer
☐ Counting aloud
☐ Other: _____

How does your child indicate "Yes" or "No" when asked a question?

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Sensory

Is your child sensitive to or avoids (mark all that apply)?

☐ Sounds or noises	☐ Specific colors	☐ Waiting	☐ Tape or Band-Aids
☐ Unexpected noises	☐ Fragrances/smells	☐ Textures	☐ Medication
☐ Bright lights	☐ Crowds	☐ Physical touch	☐ Other:_____

Does your child seek specific sensory input (mark all that apply)?

☐ Deep Pressure	☐ Sounds	☐ Oral or Mouthing	☐ Movement
☐ Touch	☐ Sights	☐ Smell	☐ Other:_____

What items would be helpful to have available (mark all that apply)?

☐ Noise-reducing headphones	☐ Puzzles/games	☐ Magazines or books
☐ Heavy blanket	☐ Scented oils	☐ Chew toys
☐ Musical instruments	☐ Sensory station	☐ Sunglasses
☐ TV or video game station	☐ Cause and effect toys	☐ Other _____

What behaviors or words does your child use when in pain?

Behavior/Safety:

What happens when your child is anxious or upset (mark all that apply):

☐ Makes sounds	☐ Tenses up body	☐ Bites or Spits
☐ Screams or cries	☐ Falls to floor	☐ Throws objects
☐ Makes specific facial expressions	☐ Hits self	☐ Elopes or tries to leave
☐ Increases physical movements	☐ Hits or grabs family members	☐ Perseverates in questioning or repetition of words
	☐ Hits or grabs others	☐ Other: _____

What is most comforting to your child when upset (mark all that apply)?

☐ Firm verbal commands	☐ Change or leave environment
☐ Verbal or physical reassurance	☐ First, Then statements
☐ Decrease sounds and lights	☐ Comfort items: _____
☐ Give him or her time to recover	☐ Distraction measures: _____
☐ Give him or her space	☐ Other:_____

What are the best ways to prepare your child for something new?

List any medications taken to help your child stay calm or manage behaviors:

Are there specific triggers we should avoid?

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General Medical experiences

How well does your child cooperate with medical visits (mark all that apply)?

- ☐ Able to follow simple commands and instructions
- ☐ Needs prompting and assistance
- ☐ Needs medication prior or during
- ☐ Parents hold to keep still during care
- ☐ Medical staff holds to keep still during care
- ☐ Generally unable to cooperate
- ☐ Restraints have been used (describe: _____ _____

Is there a part of an exam that may bother your child (mark all that apply)?

- ☐ Stethoscope on chest/back
- ☐ Checking blood pressure
- ☐ Checking height and weight
- ☐ Eyes or pupils check
- ☐ Ear check
- ☐ Mouth or throat check
- ☐ Belly exam
- ☐ Testing reflexes
- ☐ Other: _____

What is the best way for us to examine your child (mark all that apply)?

- ☐ Communicate before each step
- ☐ Simple and direct language
- ☐ One Voice
- ☐ Time to process
- ☐ Rewards and Praise
- ☐ Pictures or Visual schedule
- ☐ List or count steps
- ☐ First > Then statements
- ☐ Allow to touch instruments
- ☐ Hide instruments till needed
- ☐ Demonstrate on someone else
- ☐ Hold by Caregiver
- ☐ Distraction
- ☐ Provide choices if possible
- ☐ Timer/warning for transitions
- ☐ Music
- ☐ Written words
- ☐ Other:_____

Has your child needed sedation or other calming medication for medical or dental care? Yes ☐ No ☐

If yes to medication, what is the name of the medication and how was it given?

If sedation or anesthesia was used, how did your child tolerate the mask induction? ☐ Cooperative ☐ Resistant

☐ Staff had to hold or restrain ☐ Not sure ☐ other _____

If sedation or anesthesia was used, how did your child wake up? ☐ Calm ☐ Fussy ☐ Aggressive ☐ Hungry

☐ Slept for long time ☐ No problems ☐ other _____

Would it help to have a wheel chair available to enter the building from the garage?

What else do you think would make medical visits a positive experience for you and your child?

Visit our website for visual supports and other resources for medical visits:
http://childrensnational.org/autismvisualresources

Send feedback about this questionnaire to BeyondtheSpectrum@childrensnational.org or call 202-476-3393.

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EEG study specific questions

If your child has had an EEG:

Was the study completed?

What went well?

What did not go well?

If you have practiced the steps of the EEG at home, are there certain words or routines you would like used during the actual procedure? (For example, stickers = leads)

Is your child sensitive to having his/her head or hair touched (ex: haircuts, shampooing, hats)?

☐ Yes ☐ No ☐ Unsure ☐ Other

For the EEG lead placement, how should we position your child:

☐ Sitting ☐ Held by caregiver ☐ Lying down ☐ Other

Would help your child if or she could explore the way the materials smell and feel?

☐ Yes ☐ No ☐ Unsure ☐ Other

Will a visual aide help your child cope and understand the EEG study?

☐ Yes ☐ No ☐ Unsure ☐ Other

Would your child want a mirror to watch the setup process and the equipment as it is applied?

☐ Yes ☐ No ☐ Unsure ☐ Other