

Ambler Pediatrics

Patient Name _____

Date of Birth _____ (circle one)
M F

M-CHAT

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

1. Does your child enjoy being swung, bounced on your knee, etc.? Yes No
2. Does your child take an interest in other children? Yes No
3. Does your child like climbing on things, such as up stairs? Yes No
4. Does your child enjoy playing peek-a-boo/hide-and-seek? Yes No
5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things? Yes No
6. Does your child ever use his/her index finger to point, to ask for something? Yes No
7. Does your child ever use his/her index finger to point, to indicate interest in something? Yes No
8. Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them? Yes No
9. Does your child ever bring objects over to you (parent) to show you something? Yes No
10. Does your child look you in the eye for more than a second or two? Yes No
11. Does your child ever seem oversensitive to noise? (e.g., plugging ears) Yes No
12. Does your child smile in response to your face or your smile? Yes No
13. Does your child imitate you? (e.g., you make a face-will your child imitate it?) Yes No
14. Does your child respond to his/her name when you call? Yes No
15. If you point at a toy across the room, does your child look at it? Yes No
16. Does your child walk? Yes No
17. Does your child look at things you are looking at? Yes No
18. Does your child make unusual finger movements near his/her face? Yes No
19. Does your child try to attract your attention to his/her own activity? Yes No
20. Have you ever wondered if your child is deaf? Yes No
21. Does your child understand what people say? Yes No
22. Does your child sometimes stare at nothing or wander with no purpose? Yes No
23. Does your child look at your face to check your reaction when faced with something unfamiliar? Yes No

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Questionnaire completed by: _____ Relationship to patient: _____
(please print)

By signing below, I certify that the above information I have provided is accurate to the best of my knowledge.

X _____

Today's Date _____