Autism Spectrum Disorder (ASD) Screening Test

Patient Information:

Name: _____Date of Test:_____

Date of Birth: _____Gender:_____Contact Information: _____

Instructions

- This screening test assesses various behaviors and communication skills associated with autism spectrum disorder.
- Please complete this form based on your observations and interactions with the patient.
- Answer each question to the best of your knowledge. If a question is not applicable, mark it accordingly.

Screening Questions

Social Interaction

- Does the patient have difficulty making eye contact?
  - ☐ Yes
  - ☐ No
- Is there a lack of interest in or difficulty with social interactions?
  - ☐ Yes
  - ☐ No
- Are there challenges in developing peer relationships?
  - ☐ Yes
  - ☐ No

Communication

- Does the patient exhibit delayed speech or language development?
  - ☐ Yes
  - ☐ No
- Is there repetitive or stereotyped language or behavior?
  - ☐ Yes
  - ☐ No

- Does the patient struggle with non-verbal communication, such as gestures or facial expressions?
  - ☐ Yes
  - ☐ No

Repetitive Behaviors

- Does the patient engage in repetitive or ritualistic behaviors (e.g., hand-flapping, lining up objects)?
  - ☐ Yes
  - ☐ No
- Is there an intense focus on specific, narrow interests?
  - ☐ Yes
  - ☐ No
- Do changes in routine or environment cause distress or resistance?
  - ☐ Yes
  - ☐ No

Scoring

- Score each question with "Yes" (1) or "No" (0).
- Total the scores for all questions.

Results:

- Total Score: _____ (Maximum score: _____)

Interpretation

Follow-Up