The Childhood Autism Spectrum Test (CAST)

Child’s Name: ............................... Age: ...................... Sex:  Male / Female

Birth Order: ............................... Twin or Single Birth: .......................

Parent/Guardian: .....................................................................................................

Parent(s) occupation: ............................................................................................

Age parent(s) left full-time education: .................................................................

Address: ................................................................................................................

................................................................................................................

Tel.No: ............................... School: ............................................................

----------------------------------------------------------------------------------------------------

Please read the following questions carefully, and circle the appropriate answer. All responses are confidential.

1. Does s/he join in playing games with other children easily?  Yes  No

2. Does s/he come up to you spontaneously for a chat?  Yes  No

3. Was s/he speaking by 2 years old?  Yes  No

4. Does s/he enjoy sports?  Yes  No

5. Is it important to him/her to fit in with the peer group?  Yes  No

6. Does s/he appear to notice unusual details that others miss?  Yes  No

7. Does s/he tend to take things literally?  Yes  No

8. When s/he was 3 years old, did s/he spend a lot of time pretending (e.g., play-acting being a superhero, or holding teddy’s tea parties)?  Yes  No

9. Does s/he like to do things over and over again, in the same way all the time?  Yes  No

10. Does s/he find it easy to interact with other children?  Yes  No

11. Can s/he keep a two-way conversation going?  Yes  No
12. Can s/he read appropriately for his/her age? Yes No
13. Does s/he mostly have the same interests as his/her peers? Yes No
14. Does s/he have an interest which takes up so much time that s/he does little else? Yes No
15. Does s/he have friends, rather than just acquaintances? Yes No
16. Does s/he often bring you things s/he is interested in to show you? Yes No
17. Does s/he enjoy joking around? Yes No
18. Does s/he have difficulty understanding the rules for polite behaviour? Yes No
19. Does s/he appear to have an unusual memory for details? Yes No
20. Is his/her voice unusual (e.g., overly adult, flat, or very monotonous)? Yes No
21. Are people important to him/her? Yes No
22. Can s/he dress him/herself? Yes No
23. Is s/he good at turn-taking in conversation? Yes No
24. Does s/he play imaginatively with other children, and engage in role-play? Yes No
25. Does s/he often do or say things that are tactless or socially inappropriate? Yes No
26. Can s/he count to 50 without leaving out any numbers? Yes No
27. Does s/he make normal eye-contact? Yes No
28. Does s/he have any unusual and repetitive movements? Yes No
29. Is his/her social behaviour very one-sided and always on his/her own terms? Yes No
30. Does s/he sometimes say “you” or “s/he” when s/he means “I”? Yes No
31. Does s/he prefer imaginative activities such as play-acting or story-telling, rather than numbers or lists of facts? Yes No

32. Does s/he sometimes lose the listener because of not explaining what s/he is talking about? Yes No

33. Can s/he ride a bicycle (even if with stabilisers)? Yes No

34. Does s/he try to impose routines on him/herself, or on others, in such a way that it causes problems? Yes No

35. Does s/he care how s/he is perceived by the rest of the group? Yes No

36. Does s/he often turn conversations to his/her favourite subject rather than following what the other person wants to talk about? Yes No

37. Does s/he have odd or unusual phrases? Yes No

SPECIAL NEEDS SECTION
Please complete as appropriate

38. Have teachers/health visitors ever expressed any concerns about his/her development? Yes No

If Yes, please specify........................................................................................................................................

39. Has s/he ever been diagnosed with any of the following?:

Language delay Yes No

Hyperactivity/Attention Deficit Disorder (ADHD) Yes No

Hearing or visual difficulties Yes No

Autism Spectrum Condition, incl. Asperger’s Syndrome Yes No

A physical disability Yes No

Other (please specify) Yes No