

Autism Spectrum Mental Health Screening

Full Name

Age

Gender

Do you often experience difficulty with social interactions?

☐ Yes ☐ No

Do you have repetitive behaviors or routines?

☐ Yes ☐ No

Do you feel sensitive to certain sounds, textures, or lights?

☐ Yes ☐ No

Do you find it challenging to adjust to changes in your routine?

☐ Yes ☐ No

Do you have intense interests in specific topics?

☐ Yes ☐ No

Additional Comments