CENTER FOR CHILDREN WITH SPECIAL NEEDS

Parent Intake Questionnaire
(Children 5 years and older)

Tufts Children's Hospital

Parents are encouraged to fill out this questionnaire together. The information you provide in this form will be kept confidential. If you have any questions or need assistance, please contact us. Please answer every question. If extra space is needed, you may include it in an email or on a separate piece of paper.

I. GENERAL INFORMATION

Person we should contact for appointment: _____ Phone: _____

Child

Last Name: _____ First Name: _____

Date of birth: _____ /_____ /_____ ☐ Male ☐ Female

Parents/Guardians

Name: _____ Address: _____

Primary phone number: _____ Secondary phone number: _____

Email: _____

Name: _____ Address: _____

Primary phone number: _____ Secondary phone number: _____

Email: _____

Child's primary language: _____ Parent's primary language: _____

Interpreter needed? ☐ Yes ☐ No

Who has legal custody of child? ☐ Mother ☐ Father ☐ Grandparents ☐ DCF ☐ Other (specify):

_____

IMPORTANT: *If you are the child's legal guardian and are not their parent, please include legal documentation of this.*

Who referred you to the CCSN? _____

Is anyone in your immediate family a patient at the CCSN? _____

Child's Primary Doctor

Name: _____

Address: _____ Phone Number: _____

Indicate if your child has seen a:

☐ Neurologist

Name: _____ Phone Number: _____

☐ Psychiatrist:

Name: _____ Phone Number: _____

☐ Developmental Behavioral Pediatrician:

Name: _____ Phone Number: _____

continued

Payment Arrangments

Primary Health Insurance: _____ Policy number: _____

Secondary Health Insurance: _____ Policy number: _____

For School Pay or Independent Educational Evaluations (IEE):

Do you have a letter from the school approving payment? ☐ Yes ☐ No
If so, please include or fax to 617-636-5621.

NOTE: *We cannot schedule a "school pay evaluation" without this letter.*

II. PRESENTING CONCERNS

Please check the reasons that you are seeking an evaluation of your child at the CCSN at this time. Indicate the level of your concern by circling the number next to it that best fits.

Presenting Concerns	Mildly concerned	Somewhat concerned	Very concerned	Extremely concerned
Learning problems with reading, writing, spelling and/or math.				
I do not agree with the school over whether my child needs services, and/or what type of services are needed.				
Problems paying attention, staying focused, remembering or finishing tasks.				
Problems sitting still, being too active, talking too much, or acting without thinking.				
Behavioral problems (does not follow rules, acts defiant, aggressive or has melt downs).				
Emotional problems (is often unhappy, depressed, nervous, worried, irritable or angry).				
Problems making or keeping friends. Difficulty with social skills and social communication.				
Difficulty with speaking or communicating, or with understanding the speech and communication of others.				
Repetitive movements (i.e. pacing, hand flapping, finger twisting, jumping)				
Insistence on sameness; Lack of flexibility and difficulty accepting changes in routines or plans				
Overly focused on certain restricted and/or unusual interests. Doesn't share the interests of others.				
Daily living skills (dressing, eating, toileting, etc) are delayed				
Mental abilities (thinking, understanding and/or solving problems) seem low for their age.				
Unusual sensitivity to noises, sensations, tastes, and/or smells which interferes with daily living.				
Medication concerns (i.e. Is there a medication that might help my child? Can my child's existing medication be changed or adjusted to work better?)				

continued

What are the main goals of this evaluation from your point of view?

_____

_____

_____

_____

What are your child's strengths and interests?

_____

_____

_____

_____

Has your child ever been diagnosed with a problem with his/her development, behavior, emotions or learning?

If yes, describe. ☐ Yes ☐ No

_____

_____

_____

Are you looking for a 2nd opinion on this diagnosis? ☐ Yes ☐ No

Are looking to transfer your child's care from another developmental specialist to the CCSN. ☐ Yes ☐ No

Has your child ever been seen at the CCSN? ☐ Yes ☐ No

By whom: _____

Do you have another child who has been seen at the CCSN? ☐ Yes ☐ No

By whom: _____

Do you believe your child is at risk of harming himself/herself or others? If Yes, please explain. ☐ Yes ☐ No

_____

_____

_____

Has your child ever been psychiatrically hospitalized? If so when? ☐ Yes ☐ No

_____

_____

_____

PLEASE NOTE: *Due to our waiting list, the CCSN is unable to provide emergency services. If you are concerned that your child is in immediate danger of harming himself/herself or others, contact 911, an emergency service provider, and/or your child's primary care provider.*

continued

III. CURRENT FUNCTIONING

Please tell us more about your child's abilities in the following areas:

Sleeping skills (Does your child go to sleep on his/her own at bedtime? Does s/he stay asleep through the night?)

_____

_____

_____

Executive skills (Can your child finish tasks such as homework or chores independently? Does s/he follow directions?)

_____

_____

_____

Managing Emotions (How does your child deal with normal emotions such as frustration, anxiety, or sadness? Does s/he get too emotional compared to other children?)

_____

_____

_____

_____

Nutrition (Does your child eat a variety of foods?)

_____

_____

_____

_____

Social skills (Does your child get along and start interactions with other children/adults?)

_____

_____

_____

_____

Play skills (How does your child play? Show imaginary or dramatic play? Play board/card games?)

_____

_____

_____

_____

continued

Adaptive skills (How well can your child take care of him/herself for their age, i.e. dressing, toileting, personal hygiene)?

Reading skills (Can your child identify letters? Read familiar/new words? Read/understand sentences?)

Writing skills (Can your child write letters? Words? Sentences? A paragraph?)

Math skills (Can your child identify numbers? Count? Add and/or Subtract? Multiple and/or divide?)

Receptive language (Does your child understand single words, sentences, or stories?)

Expressive language (Does your child usually speak in single words or full sentences? Can s/he tell a story?)

continued

Gross motor skills (How well can your child sit, stand, walk, and run? Is s/he clumsy?)

_____

_____

_____

Fine motor skills (Does your child have difficulty with buttons? Zippers? Writing? Tying shoes?)

_____

_____

_____

IV. MEDICAL INFORMATION

Is this child adopted? ☐ Yes ☐ No At age _____ from (country) _____

A. Pregnancy, Labor and Delivery History

How many times has mother been pregnant? _____ How many children does mother have? _____

Birth order of this child? _____ Age of mother when this child was born? _____

Was mother healthy during the pregnancy of this child? If yes, explain. ☐ Yes ☐ No

_____

_____

Were there medical or other problems during the pregnancy or delivery? Explain below.

☐ Fertility treatment ☐ Infections (including herpes) ☐ Unusual exposures

_____

_____

Did mother have any of the following tests: ☐ ultrasounds ☐ amniocentesis ☐ CVS ☐ Other:

_____

_____

Were any of them abnormal? Explain:

_____

_____

Did mother take/use any of the following during pregnancy?

☐ prescription medications:_____

☐ over the counter medications: _____ ☐ herbal remedies: _____

☐ drank alcohol (e.g. wine, beer), _____ # drinks/day _____

☐ smoked cigarettes, _____ # packs per day ☐ drugs taken (e.g. marijuana, cocaine): _____

continued

B. Birth History

Baby was born at _____ weeks Birth weight? _____ lbs. _____ oz. Twin or triplet? ☐ Yes ☐ No

Mode of delivery: ☐ Vaginal ☐ Cesarean Section Were there problems? If yes, describe. ☐ Yes ☐ No

_____

Did your child go to the special care nursery or NICU? ☐ Yes ☐ No If yes, # of days: _____

Why? _____

Did your child have any problems in the first few days of life? If yes, describe. ☐ Yes ☐ No

_____

Did your child have feeding problems as a newborn or infant? If yes, describe. ☐ Yes ☐ No

_____

C. Medical History (Review of Systems)

Are the child's immunizations up to date? ☐ Yes ☐ No

Please indicate if your child has ever had any of the following:

☐ Problems with vision	☐ Unusual reaction to immunization	☐ Heart problems
☐ Problems with hearing	☐ Seizures, convulsions or staring spells	☐ Too fast heart beat or chest pain
☐ Serious infections/illness	☐ Head injury/lost consciousness	☐ Problems with vomiting, diarrhea or constipation
☐ Serious injury/burn/broken bones	☐ Frequent headaches/migraines	☐ Frequent stomachaches
☐ Poisoning or exposure to toxic chemicals (e.g. lead)	☐ Fainting spells/dizziness	☐ Problems with kidney, bladder or urine
☐ Hospitalizations or surgeries?	☐ Problems with restless sleep or snoring	☐ Blood problems or anemia
☐ Frequent accidents/injuries	☐ Serious nose, mouth or throat problems	☐ History or suspicion of physical or sexual abuse
☐ Serious/chronic health problem (e.g. diabetes)	☐ Serious ear infections or ear tubes	☐ History or suspicion of tobacco, alcohol or drug use
☐ Over eats or overweight	☐ Motor tics (blinking, squinting, head tossing)	☐ If female, has gotten her period
☐ Small for age or underweight	☐ Vocal tics (grunting, throat clearing)	☐ Thyroid or hormone problems
☐ Difficulties with eating, diet, or appetite	☐ Breathing or lung problems	☐ Problems with gait (the way s/he walks)
☐ Birth defect or birth marks	☐ Compulsive behaviors	☐ Mental health problems

continued

Does your child have any allergies? If yes, list. ☐ Yes ☐ No

_____

_____

_____

D. Medication History

Does your child take prescription medications? ☐ Yes ☐ No

Medication	Current or past?	Prescribed by	Why?

continued

V. FAMILY AND SOCIAL HISTORY

Who does the child live with most of the time? ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather
☐ Adoptive Mother ☐ Adoptive Father ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle
☐ Foster parent ☐ Group Home ☐ Brother(s) ☐ Sister(s) ☐ Cousin(s) ☐ Other

_____

Parent Name: _____ Relationship to child: _____

Occupation: _____ Highest level of school completed: _____

Parent Name: _____ Relationship to child: _____

Occupation: _____ Highest level of school completed: _____

Child's siblings or other children IN the home:	**Full, half, adoptive, step, etc.**	**Age**

Child's siblings NOT living in the home:	**Full, half, adoptive, step, etc.**	**Age**

Are there any special circumstances in the family situation? (Attach separate sheet if necessary)

_____

_____

_____

_____

Has the child had a very upsetting experience? (e.g. witnessed violence, physical or sexual abuse) ☐ Yes ☐ No

Has the child ever lived in an out-of-home placement? (e.g. foster care, residential center) ☐ Yes ☐ No

Are there frequent arguments and/or physical abuse in the home? ☐ Yes ☐ No

Are there family problems that may be bothering the child? ☐ Yes ☐ No

(e.g. serious illness, family members with mental health problems, divorce, financial problems, housing problems)

continued

VI. DEVELOPMENTAL HISTORY

At what age did you become concerned with your child's development? Why?

_____

_____

_____

_____

Does anyone in your immediate or extended family have/or had any of the following problems? (specify who):

- ☐ Attention problems/ ADHD: _____
- ☐ Behavior problems: _____
- ☐ Speech/language problems: _____
- ☐ School problems: _____
- ☐ Reading problems/ dyslexia: _____
- ☐ Seizures/neurological problems: _____
- ☐ Mental Retardation/ Intellectual Disability: _____
- ☐ Genetic Disorder/ birth defect: _____
- ☐ Tics/Tourette's Syndrome: _____
- ☐ Autism Spectrum Disorder: _____
- ☐ Thyroid problems: _____
- ☐ Heart problems before 50: _____
- ☐ Physical or sexual abuse: _____
- ☐ Depression: _____
- ☐ Bipolar/ Manic Depression: _____
- ☐ Social problems/ shyness: _____
- ☐ Anxiety/Panic attacks: _____
- ☐ Obsessive-Compulsive Disorders: _____
- ☐ Schizophrenia: _____
- ☐ Alcohol problems: _____
- ☐ Drug problems: _____
- ☐ Trouble with the law: _____

Has your child ever lost skills? If yes, when and what skills? ☐ Yes ☐ No

_____

_____

_____

_____

continued

When did your child begin to:	Age:	Not yet	When did your child begin to:	Age:	Not yet
Sit independently		☐	Stay dry during the day (toileting)		☐
Crawl independently		☐	Stay dry at night (toileting)		☐
Walk independently		☐	Dress/undress self		☐
Wave “bye bye”		☐	Feed self		☐
Point/show objects to others		☐	Write name, letters, colors		☐
Pretend/imaginary play		☐	Show interest in counting		☐
Speak in two word sentences		☐	Throw/ catch a ball		☐
Be understood by strangers		☐	Read simple words		☐

Please indicate if any of the following is TRUE of your child:

- ☐ Does not make good eye contact when talking to you
- ☐ Doesn’t use gestures to communicate (i.e. pointing)
- ☐ Echoes words or phrases
- ☐ Speaks in an unusual tone or manner
- ☐ It is hard to get child’s attention
- ☐ Seems preoccupied, aloof or distant
- ☐ Has repetitive movements (examples: flaps hands, twists fingers, paces back and forth)
- ☐ Doesn’t try to use words to communicate
- ☐ Prefers to be alone; ignores others
- ☐ Difficulty relating to peers or making friends
- ☐ Has unusual play behaviors; little pretend play
- ☐ Has unusual or very intense interests
- ☐ Takes things literally; misses the point
- ☐ Handles change poorly; insists on sameness

continued

VII. SOCIAL, EMOTIONAL & BEHAVIORAL HISTORY

Please describe your child's personality and mood in general:

_____

_____

_____

_____

Please indicate how often your child exhibits the following:	**Never**	**Sometimes**	**Often**	**Very Often**
1. Makes many careless errors and doesn't pay attention to details				
2. Has difficulty concentrating on difficult tasks				
3. Does not seem to listen when spoken to directly				
4. Doesn't finish tasks (such as schoolwork); shifts from one activity to another				
5. Has difficulty organizing tasks, belongings or activities				
6. Avoids and dislikes tasks that require concentration or effort				
7. Loses or misplaces things				
8. Is easily distracted by noises or other things				
9. Is forgetful in daily activities				
10. Fidgets with hands; squirms in seat				
11. Has difficulty remaining seated when asked				
12. Runs or climbs when told not to				
13. Has difficulty playing quietly				
14. Is "on the go"; Acts like "driven by a motor"				
15. Talks too much				
16. Blurts out or answers questions before they have been completed, talks before thinking				
17. Has difficulty awaiting turn				
18. Interrupts (butts into conversations or games)				
19. Lose his/her temper				
20. Argues with adults				
21. Defies or refuses to do as asked				
22. Deliberately annoys others				
23. Blames others for own misbehavior or mistakes				
24. Is touchy or easily annoyed by others				
25. Is angry or resentful				
26. Tries to get even or takes out anger on others				
27. Is aggressive to people and/or animals (e.g. bullies/threatens others; starts fights; has used a weapon; physically cruel to people/animals; has robbed/mugged someone; forced someone into sex)				
28. Has deliberately destroyed property of others				
29. Does serious lying, cheating, and/or stealing things of value				

continued

Please indicate how often your child exhibits the following:	**Never**	**Sometimes**	**Often**	**Very Often**
30. Stays out all night without permission, runs away or skips school				
31. Loss of interest or pleasure in everyday activities				
32. Changes in appetite or weight				
33. Difficulty with sleep (e.g. staying asleep, falling back asleep, sleeps too much)				
34. Feels useless or not as good as others (e.g. low self-esteem, blames self for problems)				
35. Is sad, unhappy or irritable (e.g. over-reacts, is easily upset, cries a lot)				
36. Low energy, tired, or fatigued				
37. Difficulty thinking, concentrating or making decisions				
38. Is fearful, anxious or worried				
39. Is restless or on edge				
40. Complains about body aches/muscle tension				
41. Can't stop worrying (germs, doing things perfectly, family in danger)				
42. Is afraid to try new things for fear of making mistakes or being embarrassed				
43. Has violent outbursts or tantrums including crying or clinging to others				
44. Worries about leaving home or being away from parents				

VIII. SCHOOL INFORMATION

Current School Name: _____

School Address and number: _____ Grade: _____

Contact Person and number: _____ Grade: _____

Has your child been evaluated for special education services? If so, when? ☐ Yes ☐ No

_____

Does your child currently receive special education services? ☐ Yes ☐ No ☐ I don't know
[If your child receives services, please include a copy of their Individual Educational Plan (IEP)]

How satisfied are you with your child's current school placement?

☐ Very Satisfied ☐ Somewhat Satisfied ☐ Not Satisfied

_____

_____

_____

_____

continued

IX. PREVIOUS EVALUATION AND OTHER SERVICE HISTORY

Private Evaluations (including psychiatrist, neurologist, developmental-behavioral pediatrician, or other professional)

Test done	With whom	Where	When

Medical Tests (including EEG, MRI, Genetics/Chromosome test, etc.)

Test done	With whom	Where	When

Please indicate any services your child receives or has received in the past OUTSIDE OF SCHOOL:

Service Type	Dates of Service	Service Provider (Name/#)
☐ Early Intervention, Why?		
☐ Social Worker / Case Manager		
☐ Speech and Language Therapy		
☐ Occupational Therapy		
☐ Physical Therapy		
☐ Tutoring		
☐ Applied Behavioral Analysis (ABA) Therapy		
☐ Mental Health Counseling (e.g. CBHI/in-home therapy, individual or family therapy)		
☐ Psychiatric or Drug Treatment Hospitalization		
☐ Department of Developmental Services (DDS)		
☐ Department of Mental Health (DMH)		
☐ Department of Children and Families (DCF)		
☐ Other:		

continued

Is there anything else you would like to share with us?

Dear Parent, thank you for completing this questionnaire. We would like to recommend that you:

- Keep a copy for your records (this is very important in case paperwork gets misplaced)
- If applicable, include your child's current IEP and any prior evaluations (school, medical, & private evaluations)
- Documents can be emailed to: CCSNForms@tuftsmedicalcenter.org or mailed to: 800 Washington Street, #334, Boston, MA 02111

We look forward to working with you and your child.