Parent Questionnaire
For children younger than 5 years old

We encourage parents/caregivers to fill out this questionnaire together. Review the entire questionnaire before completing it. Since this questionnaire is used for a wide range of ages and disabilities, some questions may not apply to your child and you may skip those. If two parents are filling out this questionnaire and have different opinions, then please use different colored ink. If you have any questions or need assistance, please contact us. **(revised 03-09)**

Child's Name: _____ Today's Date: _____

Nickname if any: _____ Date of Birth: _____ Age: _____ Sex: Male / Female

Ethnic Background (optional): White African-American Hispanic Native American

Asian Pacific Islander Other: _____

Person Completing Form: _____Relationship to Child _____

Child's Address: _____ _____
Street City

_____ _____
State Zip code

Parent 1 Name: _____Relationship to Child: _____

Parent 1 Address (if different from child's): _____
Street City State Zip code

Home Phone: (____) _____Cell Phone: (____) _____Work Phone:(____)_____

Parent 2 Name: _____Relationship to Child: _____

Parent 2 Address (if different from child's): _____
Street City State Zip code

Home Phone: (____) _____Cell Phone: (____) _____Work Phone:(____)_____

Language(s) spoken at home, from most-used to least:1) _____2)_____3)_____

Interpreter needed? __No __Yes

Child's Primary Care Doctor: _____Phone: (_____) _____

Doctor's Complete Address: _____

PAYMENT/INSURANCE INFORMATION

Please indicate method of payment:

__ Self-Pay

__ School to Pay (** Please refer to enclosed yellow sheet about Independent Evaluations: we require a letter from your school system that states their willingness to pay for the evaluations at our approved rate **)

__ Health Insurance (*please note that most companies do not pay for educational evaluations)

Name of Health Insurance/HMO_____

Subscriber's Name: _____Date of Birth: _____ Policy #: _____

I. PARENT CONCERNS

1. Please describe your main concerns about your child:

2. When did you first worry about these problems?

3. Have you talked to your pediatrician about your concerns? When?

4. What have you tried to do about these problems in the past?

5. What are your child's special qualities and strengths?

II. CHILD'S BIRTH HISTORY

Is this child adopted? __ No __ Yes At age ___ months/years from (country)_____

Pregnancy, Labor and Delivery History	Yes	No	Comments
1. Age of mother when child was born: ____ years			
2. Is this child a twin or triplet?			
3. Any problems with other pregnancies? Miscarriages?			
4. Use *in vitro fertilization* or other method of conception?			
5. Were there any problems during this pregnancy?			
6. Any medications prescribed? Why?			
7. Gestational diabetes (sugar in urine)?			
8. Any problem with blood pressure or toxemia?			
9. Any problems with infections (including herpes)?			
10. Smoking during pregnancy? How many packs per day?			
11. Drank alcohol (beer, wine, etc) during pregnancy?			
12. Any street drugs (marijuana, cocaine, etc.) used?			
13. Any problems during labor or delivery?			
14. Cesarean delivery? Why?			
15. Baby was born at _____ weeks			

Newborn History	Yes	No	Comments
1. Birth weight? _____ lbs. _____oz.			
2. Were there any problems at birth or as a newborn?			
3. Were any birth defects or birth injuries noted?			
4. Put in Special Care or Intensive Care Nursery? ____days			
5. Have jaundice and need phototherapy?			
6. Very jittery or lethargic as a newborn?			
7. Baby had to stay extra days in the hospital? ____days			

III. INFANT TEMPERAMENT

Please describe your child as an infant or toddler: _____

_____

More infant temperament…	Yes	No	Comments
1. Problems with feeding in infancy?			
2. Severe or prolonged colic or excessive crying?			
3. Difficult temperament (irritable or demanding)?			
4. Excessively wiggly or active?			
5. Easily over-stimulated?			
6. Passive, shy or withdrawn?			
7. Didn't like to be held or cuddled?			
8. Trouble keeping a babysitter?			

IV. CHILD'S MEDICAL HISTORY

	Yes	No	Please comment below if "Yes"
1. Problems with vision? Crossed eyes? Wears glasses?			
2. Problems with hearing?			
3. Serious or chronic health problem (such as diabetes)?			
4. Birth defect or birthmarks?			
5. Hospitalizations or surgery?			
6. Serious infections or illness (e.g. meningitis)?			
7. Serious injury, burn or broken bones?			
8. Head injury or lost consciousness?			
9. Frequent accidents or multiple minor injuries?			
10. Poisoning or exposure to toxic chemicals (e.g. lead)?			
11. History or suspicion of physical or sexual abuse?			
12. Fainting or dizziness?			
13. Seizures, convulsions or febrile seizures? staring spells?			
14. Staring episodes or spells?			
15. Motor tics (repeated blinking, squinting, head tossing)?			
16. Vocal tics (repeated grunting, throat clearing noises)?			
17 Compulsive mannerisms (hand washing, picking, counting)?			
18. Multiple ear infections? Chronic antibiotics or ear tubes?			
19. Serious nose, mouth or throat problems?			
20. Thyroid disorders or other hormone problems?			
21. Breathing or lung problems (pneumonia, asthma)?			
22. Too fast heart beat (palpitations) or chest pains?			
23. Frequent aches and pains?			
24. Problems with vomiting, diarrhea or constipation?			
25. Problems with kidneys, bladder or urine?			
26. Blood problems or anemia (iron deficiency or low blood count)?			
27. Difficulties with eating, diet or appetite?			
28. Small for age or underweight?			
29. Over eats or overweight?			
30. Problems with restless sleep or snoring?			
31. Allergies to medications? Specify.			
32. Other allergies? Specify.			
33. Any vitamin supplements? Specify.			
34. Any herbal medicines or other nutritional supplements?			
35. Any non-medical treatments (special diet, chiropractic, acupuncture, etc.)?			
36. Unusual reaction to immunization?			
36. Are immunizations up to date?			

V. CHILD'S SOCIAL DEVELOPMENT

1. Describe your child's temperament or personality. _____

_____

2. How does your child get along with adult members of the family? _____

_____

3. How does your child get along with adults outside the family? _____

_____

4. How does your child get along with siblings? _____

_____

5. How does your child get along with playmates/peers? _____

Please think about your child's behavior over the past 6 months. Circle the answer that best describes how often you have noticed each kind of behavior.

1. Is your child interested in playing with other children?

Very Often Often Sometimes Rarely Never

2. When you say a word or wave your hand, does your child try to copy you?

Very Often Often Sometimes Rarely Never

3. Does your child look at you when you call his or her name?

Very Often Often Sometimes Rarely Never

4. Does your child look if you point to something across the room?

Very Often Often Sometimes Rarely Never

5. Does your child bring things to you to show them to you?

Many times a day A few times a day A few times a week Less than once a week Never

6. How does your child <u>usually</u> show you something he or she wants?

Says a word for it | Points to it with one finger | Reaches for it | Pulls me over or puts my hand on it | Grunts, cries, or screams

7. What are your child's favorite play activities?

Playing with dolls or stuffed animals | Reading books with you | Climbing, running, and being active | Lining up toys or other things | Watching things go round and round like fans or wheels

VI. CHILD'S DEVELOPMENTAL HISTORY

Area of Development		**My Child is Doing OK**	**I'm a little worried**	**I'm somewhat worried**	**I'm very worried**
1.	General development				
2.	Speech and language skills				
3.	Motor skills				
4.	Feeding/Eating				
5.	Sleeping				
6.	Cognitive/thinking skills				
7.	Social skills				

Did your child seem to develop normally but then lose developmental skills? NO YES

If yes, describe: _____

The following questions are about your child's communication skills. Please answer if/when your child could…		**Not yet**	**Yes**	**At What Age?**
1.	Understand and respond to name?			
2.	Understand simple commands?			
3.	String sounds together (*uh oh, gaga, bada, dada, mama*)?			
4.	Pretend talk (with inflections that sound like conversation)?			
5.	Say first word (that he/she then used consistently)?			
6.	Put two words together (*want cookie, Mommy work, Dad car*)?			
7.	Use pronouns to refer to self and others?			
8.	Strangers understand most of what he/she says?			
9.	Attends to a short story and answers simple questions about it?			
10.	Speak in fairly complex sentences?			
The following questions are about your child's motor skills. Please answer if/when your child could…		**Not yet**	**Yes**	**At What Age?**
1.	Sit up without being held or propped?			
2.	Crawl or scoot?			
3.	Walk alone?			
4.	Jump off the floor with both feet?			
5.	Throw a ball?			
6.	Catch a medium-sized ball?			
7.	Pick up small objects with thumb and one finger?			
8.	Unwrap loosely wrapped small objects?			
9.	String half-inch-sized beads on a string?			
10	Copies letters?			
The following questions are about your child's self-help skills. Please answer if/when your child could…		**Not yet**	**Yes**	**At What Age?**
1.	Feed self using spoon in scooping motion?			
2.	Feed self using fork to prick food?			
3.	Help you in dressing/undressing him/herself?			
4.	Unzip a zipper?			
5.	Unbutton front buttons?			
6.	Toilet-trained in day?			
7.	Toilet-trained at night?			
8.	Wash/dry hands by himself/herself?			
The following questions are about your child's pre-academic skills. Please answer if/when your child could…		**Not yet**	**Yes**	**At What Age?**
1.	Identify basic colors consistently?			
2.	Identify shapes consistently?			
3.	Identify several letters consistently?			
4.	Count 2-3 objects correctly?			
5.	Can state the use of objects (e.g. car, fork)?			

VII. CHILD'S BEHAVIORAL HISTORY

1. How do you usually handle misbehavior? _____

_____

2. How does your child respond to being told "no" or being corrected for misbehaving? _____

_____

3. How does your child respond to praise, rewards or positive reinforcement? _____

_____

4. Do you and your partner agree on how to handle misbehavior? Usually Agree Sometimes Agree Often Disagree

Please answer how often the below items describe your child's behavior.

The following questions are about your child's sensory experiences.		**Never**	**Some-times**	**Often**	**Very Often**	**Office Notes**
1.	Unusually sensitive hearing or sense of smell					
2.	Bothered by how things feel (clothes, being hugged)					
3.	Over- or under-sensitive to pain					
4.	Easily over-stimulated; winds up or shuts down					
5.	Unusual or limited diet					
6.	Hurts herself/himself on purpose					
7.	Eats things that are not food ("pica")					
8.	Unaware of dangerous situations					
The following questions are about repetitive behaviors or habits.		**Never**	**Some-times**	**Often**	**Very Often**	**Office Notes**
1.	Echoes words or phrases					
2.	Hard to get child's attention					
3.	Prefers to be alone; ignores others					
4.	Does things just to get you to laugh					
5.	Handles change poorly; insists on same routines					
6.	Excessive or public masturbation					
7.	Excessive thumb-sucking or nail-biting					
8.	Other habits (e.g. pulls out hair or lashes)					
The following questions are about your child's ability to handle anxiety.		**Never**	**Some-times**	**Often**	**Very Often**	**Office Notes**
1.	Is fearful, anxious or worried					
2.	Doesn't try new things for fear of making mistakes					
3.	Is sad, unhappy or depressed					
4.	Has unusually hard time being away from parents					
5.	Refuses to speak except to family members					
6.	Resists going to school					

The following questions are about your child's ability to follow rules and routines. Please answer how often your child…		Never	Some-times	Often	Very Often	Too Young	Office Notes
1.	Has temper tantrums						
2.	Argues with adults						
3.	Defies or refuses to do as asked						
4.	Deliberately annoys others						
5.	Is angry or resentful						
6.	Tries to get even or takes out anger on others						
7.	Blames others for misbehavior						
8.	Bullies, threatens or intimidates others						
9.	Does serious lying or cheating						
10.	Starts physical fights						
11.	Is cruel to animals						

Please review the following items and indicate if they describe your child's behavior.

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

VIII. FAMILY COMPOSITION

Child lives with: __ Biological Mother __ Biological Father __ Stepmother __ Stepfather __Partner
__ Adoptive Mother __ Adoptive Father __ Foster Mother __ Foster Father __Guardian
__ Other Adult (e.g. grandparent or boyfriend) Specify: _____

Biological mother's name: _____

Age: ____ **Occupation:** _____ Highest level of school completed: _____

Biological father's name: _____

Age: ____ **Occupation:** _____ Highest level of school completed**:** _____

Adoptive/step/other mother name: _____ **Occupation:** _____

Highest level of school completed**:** _____

Adoptive/step/other father name: _____ **Occupation:** _____

Highest level of school completed _____

Additional adults: _____

_____

Parents' Marital Status: __ Married __ Never married __ Separated / Divorced __ Widowed

How do the parents get along with each other?

_____

If separated/divorced, how long? _____

Contact with non-custodial parent or custody arrangements: _____

_____

Child care arrangements: _____

_____

_____

Any special circumstances in the family situation? _____

_____

What does the family enjoy doing together? _____

_____

_____

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

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

IX. FAMILY HISTORY

Biological Family Medical and Psychiatric History (if adopted indicate information on any known biological relatives and indicate information on adoptive family members on lines below)

Any one in this child's biological family have:	**Yes**	**No**	**How is this person related to child:**
Attention problems/ADHD			
Behavior problems as child or teen			
Speech or language problems			
School problems			
Reading problems or dyslexia			
Seizures or neurological problem			
Unusual drug reaction			
Mental retardation			
Birth defect or genetic disorder			
Tics/Tourette's Syndrome			
Autism spectrum disorder or PDD			
Thyroid problems			
Heart problems before age 50			
Physical or sexual abuse			
Depression			
Bipolar / manic depression			
Social problems/shyness			
Anxiety or panic attacks			
Obsessive-compulsive disorder			
Schizophrenia			
Alcohol problems			
Drug problems			
Trouble with the law			

Other problems that run in biological family:_____

_____

Other problems that run in step-, adoptive or foster family: _____

_____

Any difficult circumstances in either parent's childhood (e.g. abuse, alcoholic parents)?

_____

_____

_____

Does anyone in the family have problems similar to this child's? If so who? _____

X. CHILD'S HOME LIFE

Stressful Life Experiences		Yes	No	Office Notes
1.	Child had a very upsetting experience (e.g. witnessed violence, physical abuse, sexual abuse, severe accident)?			
2.	Moved? Number of moves: _____			
3.	Out of home placement (foster care, residential center)			
4.	Family problems that may be bothering child?			
5.	Divorce/separations/remarriage?			
6.	Frequent arguments and/or physical abuse in home?			
8.	Serious physical illness in parent, caregiver or sibling?			
10.	Serious money or housing problems?			
11.	Concerns about safety in neighborhood?			
12.	Are there guns in the house?			

How much time per day does your child usually spend watching TV? _____

How much time per day does your child usually spend on computer/video games? _____

XI. CHILD'S SERVICES HISTORY

Placement, Programs and Services (now or in the past)	**# days/ week**	**# min/ session**	**Comments**
Early Intervention Program (0 to 3 years)? Name:_____			
Developmental specialist:			
Speech/Language Therapy			
Occupational Therapy?			
Physical Therapy?			
Play Group?			
Behavior Therapy (also known as ABA or Floortime)? Provider:_____			
Day Care: Name: _____			
Pre-school: Name:_____ School district:_____ Teacher: _____ Phone: _____ # of teachers/aides:_____ # students:_____ Does your child have his/her own 1:1 aide? _____			

Ever suspended from school or daycare? _____

Ever received any other special education or therapeutic services? ____ If yes, please specify: _____

_____

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

Very Satisfied Somewhat satisfied Not satisfied

Comments: _____

_____

_____

XII. CHILD´S PREVIOUS EVALUATIONS AND TREATMENTS

Please indicate if your child has had any previous evaluations and attach any reports.

Has your child had other evaluations? (including school, psychologist, neurologist or other specialist doctors)

Year	Professional's Name	Type of Testing

MEDICAL TESTS including EEG, MRI, Chromosome test, etc.?

Year	Type of Testing	Results

Has your child received private counseling?

Therapist	Date Started	Date Stopped

Has your child taken medication for attention, behavior or emotional problems? _____Yes _____ No

Medication (e.g. Ritalin Sustained Release)	Dosage (e.g. 20 mg 3x day)	Month/year Started	Month/year Stopped	Effects or Adverse Effects

XIII. OTHER INFORMATION

Please add any other information you think may help us understand your child.

_____

_____

_____

_____

_____

Thank you.

Parent and Teacher Questionnaires were developed by the Center for Children with Special Needs, Floating Hospital for Children, Tufts Medical Center #334, 800 Washington Street, Boston, MA 02111. (617) 636-7242.

PLEASE CONTINUE TO THE NEXT PAGE.

Center for Children with Special Needs

TWO-WAY RELEASE OF INFORMATION

CHILD'S NAME:_____ **Date of Birth:**_____
I hereby give permission to the Center for Children with Special Needs of Tufts Medical Center to exchange information and records relative to my child's evaluation. This means that the individuals and agencies listed below have my authorization to release their records pertaining to my child's evaluation to the CCSN, and also means that the CCSN can release records to the individuals and agencies listed below. This release of information also gives permission for the CCSN and the individuals and agencies listed below to exchange information by telephone.

- Reports of evaluations by developmental-behavioral pediatricians are routinely sent to parents and the child's primary care provider.

- If my child's school is funding these evaluations, I give permission to send the results of my child's testing to the school system, which has contracted with the CCSN. In such case, I understand that if I do not give permission for these records to be released, I am financially responsible for payment of the evaluations.

Primary Care Physician
Name:

Address:

Telephone #:

Early Intervention Provider/Preschool/School: (*If your child is in school or Early Intervention, it is helpful to be able to contact their providers at these programs)*

Program Name: **Contact Name:**

Address:

Telephone #:

Other:

Address:

Telephone #:

_____ _____ _____
Date **Signature** **Relationship to child**

<u>OPTIONAL</u> TWO-WAY RELEASE OF INFORMATION BY EMAIL

I wish to send e-mail about my child's health care to my clinician (doctor or other allied health professional) at CCSN, Tufts Medical Center ("Clinician"), and I request that my Clinician exchange information including sending e-mail about my child's health care to me, other clinicians or specified school personnel.

I authorize my Clinician to send me e-mail at the following e-mail address, including e-mail containing my child's protected health information (the privacy of which is protected under federal and state law):

Parent email [Please print clearly]: _____@_____

I have read and understand the contents of this Consent and Release (see Email Communication Guidelines on next page) and agree to the terms. I understand that email is for NON-URGENT matters only.

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Name (print): _____

E-mail Communication Guidelines

I understand and agree to the following guidelines for e-mail communication:

•Urgent matters or emergencies should not be the subject of e-mail correspondence. I will contact my Clinician directly regarding such matters.

•I understand that, due to various technical limitations, unpredictably, e-mails may be delayed and some e-mail may never be delivered. In addition, there is no certainty that my Clinician will in fact read the e-mail in a timely fashion, even if it is delivered without delay. For example, my Clinician may be out of town or ill. I will contact my Clinician's office by telephone if I do not receive a response to an e-mail or if I require a faster response than e-mail allows.

•Certain issues are appropriately addressed only through an office visit. My Clinician will inform me if he/she believes that a particular issue is inappropriate for e-mail and requires an office visit.

•E-mail messages I send to Clinician should be as concise as possible and should include my full name and my child's name and hospital card number.

•To preserve confidentiality, certain kinds of sensitive information (for example, information relating to sexually transmitted diseases, or alcohol or substance abuse treatment) should not be the subject of e-mail communication.

•My refusal to adhere to these guidelines shall be grounds for termination by my Clinician of e-mail correspondence.

Additional Terms

I understand the security and privacy limitations of e-mail communication which apply to the communications contemplated in this Consent. Specifically:

• I understand that my Clinician and Tufts Medical Center do not encrypt e-mail, and therefore it may be subject to interception on the internet. This could result in breaches of the confidentiality and privacy of my health information.
• I understand that due to the inherent nature of the Internet, e-mail may be read by un-intended recipients who may or may not be identified. For example, I understand that e-mail may be read by personnel at my commercial e-mail service provider, if I am using such a service provider, and I will check with my service provider if I need clarification or more information.
• If the e-mail account I have identified above is maintained by my employer, I understand that my employer may gain access to any health information that I e-mail or that my Clinician e-mails to me at this account, and I will check with my employer if I need clarification or more information.
• I understand that neither Clinician nor Tufts Medical Center will use my e-mail address for marketing purposes.
• I understand that I may revoke this authorization at any time by providing written notice to my Clinician; however, e-mail communication may continue until the revocation is received and processed.

Release from Liability

I hereby indemnify and hold harmless Clinician, Tufts Medical Center, and his/her and its respective employees, agents, officers, directors, contractors and affiliates from any liability relating to or arising out of the loss of information transmitted or attempted to be transmitted by e-mail, any delay in e-mail transmission, any interception by unauthorized recipients, or breach of confidentiality or privacy resulting from technical or process failures of any nature, and from any liability relating to or arising out of any breach of my confidentiality or privacy which may result from the use of unencrypted e-mail.

Email consent.v.11.30.07

Parent / Guardian: Please complete this portion before giving it to the child's school.

Student's Name: _____ Date of Birth: _____

I give my permission for the school to send information about my child to the CCSN:

Parent/guardian signature: _____ Date: _____

Center for Children with Special Needs
Floating Hospital for Children
Mailing address: **800 Washington Street, #334**
Tufts Medical Center
Boston, MA 02111
Telephone: (617) 636-7242
Chelmsford: 978-937-6362
Woburn: 781-897-0240
Framingham: 1-866-618-5518
Leominster: 978-514-6300
Website: www.ccsnBoston.org

School Questionnaire (revised 10-07)

Child's Name: _____Gender: M F Age:_____ Grade:_____

Date Completed: _____ Person Completing Form:_____Title:_____

Name of School: _____ School District: _____ State: ____ _____

Main Teacher: _____ Email:_____

Guidance Counselor:_____ Email:_____

School Phone:_____ School Fax:_____

School Address:_____

Type of School: Public Parochial Private Specialized Private Other:_____

Is the child in Special Education? No Yes since _____ (year) Classified as:_____

How long have teachers been concerned about this student? _____

Please describe the **teachers' main CONCERNS** at this time: **Please check if continued on last page** ☐

_____

_____

_____

_____

_____

_____

_____

Please comment on this **student's STRENGTHS**:

_____

_____

_____

Please comment on the **student's weakest areas** in school:

_____

_____

Is this student **gifted** in any areas?

History: Past and Current School Problems

For each of the following grades this student has completed, **were any problems reported**? If YES, please describe:				
			Academics	**Behavior**
Yes	No	Preschool & Kindergarten		
Yes	No	First & Second Grade		
Yes	No	Third, Fourth & Fifth Grade		
Yes	No	Middle School		
Yes	No	High School		

History: School Intervention

	Yes	**No**	**Comments**
1. Was this student in an **Early Intervention Program?** Specify:			
2. Has this student ever received **home-based services**? Specify:			
3. Was this student in a **special preschool program or Head Start?** Specify:			
4. Has this student ever **repeated a grade or subject**? If yes, which grade(s)? ___			
5. Has this student ever attended **summer school**? If yes, which grade(s)? ___			
6. Has this student **ever failed any competency exams (e.g. MCAS, other state testing)**? Specify:			
7. Has this child had any **non-special education academic support** through the school district or privately? Specify:			
8. Has this student ever needed any **behavioral interventions**? Specify:			
9. Have any **disciplinary actions** been taken (suspension or expulsion)? Specify:			
10. Has this student ever had a **504 plan**? If yes, when did it start? ____(Year or grade.) Is this student still on a 504 plan? Yes No N/A			

11. Has this student ever had an **IEP** and received special education services? If yes, when did it start? _____ (Year or grade.) Is this student still on an IEP? Yes No N/A			
12. Has this student been placed in any **special classes, programs or schools**? Specify:			
13. Has this student ever had **speech, occupational, or physical therapy**? Specify:			
14. Do you know if this student has ever taken any **medications for attention, behavioral or emotional problems**? Specify:			
15. Have any particular **programs or methodologies been necessary for this student to learn c**ompared to other students in reading, math, or written language? Specify:			
16. Have any particular **behavioral strategies** been necessary with this student? Specify:			

Current Services: **Please complete if IEP is not attached.**

Current Services	Individual/ Group Size	Minutes	Frequency	In-class/ Pull-out/Other	Treatment Goals
Special Education					
Speech/Language					
OT					
PT					
Counseling					
Tutoring in school					
Other Services:					

Testing:

Name of Test (No abbreviations, please.)	Date Given	Grade/Year
Cognitive, Intelligence Testing		
Educational achievement Test		
Visual/Motor Integration Testing		
Speech/Language Testing		
Other:		

****Please attach any standardized testing, report cards, school team summaries, or IEPs available for this student. ****

Current: Behavior

Check the box that best describes this student's behavior over the past 6 months. Please check if behavior rated is: ☐ **On Medication** ☐ **No Medication** ☐ **Don't Know**	**Never/ Rarely 0**	**Some-times 1**	**Often 2**	**Very often 3**
1. **Fails to pay close attention to details** or **makes careless mistakes** in schoolwork.				
2. Has **difficulty sustaining attention** to tasks or activities.				
3. **Does not listen** when spoken to directly.				
4. **Does not follow through** on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand).				
5. Has **difficulties organizing** tasks and activities.				
6. Avoids, dislikes, or is **reluctant to engage in tasks** that require sustained mental effort.				
7. **Loses things** necessary for tasks or activities (school assignments, pencils, books).				
8. Is **easily distracted** by extraneous stimuli.				
9. Is **forgetful** in daily activities.				
10. **Fidgets** with hands or feet or squirms in seat.				
11. **Leaves seat** in classroom or other situations when remaining seated is expected.				
12. **Runs about or climbs excessively** when remaining seated is expected.				
13. Has **difficulty playing** or engaging in leisure activities quietly.				
14. Is **"on the go"** or acts as if "driven by a motor."				
15. **Talks excessively.**				
16. **Blurts out answers** before questions have been completed.				
17. Has **difficulty waiting in line**.				
18. **Interrupts** or intrudes on others (e.g., butts into conversations or games).				
19. **Loses temper**.				
20. Actively **defies or refuses** to comply with adult's request or rules.				
21. Is **angry or resentful**.				
22. Is **spiteful** and **vindictive.**				
23. **Bullies**, threatens, or scares others.				
24. **Initiates physical fights**.				
25. **Lies** to obtain goods or favors, or to avoid obligations (e.g., "cons" others).				
26. Is **physically cruel** to people.				
27. Has **stolen items of nontrivial value.**				
28. Deliberately **destroys others' property.**				

(OFFICE USE ONLY) 1--9: ____ **/ 9** IA: ≥ 6 / 9 10--18: ____ / 9 HI: ≥ 6 / 9 19--28**:** ____ / 10 ODD / CD: ≥ 3 / 10 29-35:____/7 AD≥3/7

Check the box that best describes the student's behavior over the past 6 months. *If the student is currently taking medication, please rate the student's behavior **NOT** on medication.*	**Never Rarely 0**	**Some times 1**	**Often 2**	**Very often 3**
29. Is **fearful, anxious, or worried**.				
30. Is **self-conscious or easily embarrassed**.				
31. Is **afraid to try new things** for fear of making mistakes.				
32. **Feels worthless or inferior**.				
33. **Blames self** for problems, feels guilty.				
34. **Feels lonely, unwanted or unloved**; complains that 'no one loves me."				
35. Is **sad, unhappy, or depressed.**				
36. Has **said things like "I wish I were dead"** or has tried to hurt self.				
37. Has **distinct periods where mood is unusually irritable OR unusually good, cheerful, or high** which is clearly excessive or different from normal mood.				
38. Seems to have **compulsions** (repetitive behaviors that this student seems driven to carry out, such as repeated hand washing, counting, or erasing until holes appear).				
39. Seems to have **obsessions** (persistent or repetitive thoughts that distress this student, such as worry about germs or doors left unlocked).				
40. **Has prolonged temper tantrums** (greater than 20-30 minutes).				
41. **Hears voices** telling the student to do bad things.				
42. Seems **unaware of others existence**, is **uninterested in interacting with others**.				
43. Has **odd, eccentric or unusual preoccupations** (e.g., clothing items, toys, neatness) or has to do things a certain way.				
44. Appears **uninterested in activities** students his or her age usually like or participate in.				
45. **Misses school/excessive absence or tardiness.**				
46. Is **hungry** or appears hungry.				
47. Is **tired** or appears tired.				
48. Is **poorly groomed**.				
49. **Complains** about events at home.				
50. Describes **problems in family** life.				

51. Is there **anything else that would be helpful** for us to know about the student or family situation?
Specify:

History: Learning Problems

We are interested in whether this student has learning problems **above and beyond** what would be expected for age.

Check the box that best describes the student's learning problems over the past 6 months.	**Never Rarely 0**	**Some-times 1**	**Often 2**	**Very often 3**
1. Has trouble **learning new material** in an appropriate time frame for age.				
2. **Unable to tell time,** days of the week, months of the year.				
3. Can't **repeat information**.				
4. **Knows material one day; doesn't know it the next**.				
5. Has trouble **keeping several different things in mind** while working.				
6. Has trouble **following multi-step directions**.				
7. **Rushes through work**.				
8. **Works too slowly**.				
9. Says things that have **little or no connection** to what others are discussing.				
10. Depends on teacher for **repetition of task instructions**.				
11. Has difficulty **copying written material** from blackboard.				
12. Difficulty **orienting self** (i.e., gets lost, can't find way).				
13. Has poor **spatial judgment** and often bumps into things.				
14. Confuses **directionality** (up/down, left/right, over/under).				
15. Has poor **spatial organization** on paper (difficulty staying in lines, maintaining space between words, staying within page margins).				
16. **Mixes up capital and lower** case letters when writing.				
17. **Reverses letters and numbers.**				
18. Has trouble **expressing words** or events in **correct order**.				
19. Often **mispronounces** known or familiar words.				
20. Has trouble **verbally expressing thoughts**.				
21. Has difficulty **distinguishing long vowel sounds and short vowel sounds**.				
22. Has **trouble expressing thoughts in writing**.				

23. Can do math computation but has **trouble with word problems**.				
24. Has difficulty **learning math facts** and common number patterns.				
25. Displays **poor word attack skills** (can't sound out words).				
26. Puts wrong **number of letters in words**.				
27. **Confuses consonant sounds**, for example: d-b, d-t, m-n, p-b, f-v, s-z.				
28. Unable to **keep place on page** when reading.				
29. **Reads slowly**.				
30. **Doesn't comprehend** what he/she reads.				

Current: Classroom Behavior

Please circle the appropriate number:	**Above Average**		**Average**	**Below Average**	
1. Understanding verbal instructions	1	2	3	4	5
2. Classroom assignment completion	1	2	3	4	5
3. Organizational skills	1	2	3	4	5
4. Getting homework to and from school	1	2	3	4	5
5. Homework completion	1	2	3	4	5
6. Relationship with peers	1	2	3	4	5
7. Following directions	1	2	3	4	5
8. Disrupting class	1	2	3	4	5
9. Verbal participation in class	1	2	3	4	5
10. Consideration of others.	1	2	3	4	5
11. Effort (e.g., tries his/her best)	1	2	3	4	5
12. Ability to recover easily from disappointments	1	2	3	4	5
13. Cognitive ability	1	2	3	4	5
14. Emotional maturity	1	2	3	4	5
15. Behavior in less-supervised situations (recess, lunchroom, playground)	1	2	3	4	5
16. Motivation to learn	1	2	3	4	5

Current: School Performance

Please circle the appropriate number:	**Exceeds Standards**		**Meets Standards**	**Below Standards**	
1. Reading decoding	1	2	3	4	5
2. Reading comprehension	1	2	3	4	5
3. Reading rate/fluency	1	2	3	4	5
4. Spelling accuracy	1	2	3	4	5
5. Mathematics concepts	1	2	3	4	5
6. Mathematics computation	1	2	3	4	5
7. Handwriting	1	2	3	4	5
8. Writing rate	1	2	3	4	5
9. Punctuation/grammar	1	2	3	4	5
10. Ability to express thoughts through writing	1	2	3	4	5
11. Gross motor skills	1	2	3	4	5
12. Fine motor skills (using pencil & scissors)	1	2	3	4	5

Current: Summary

Please **summarize this student's <u>OVERALL</u> functioning** (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing **ONE** number below. Compare this student's functioning in 2 settings—at school and with peers—to "average students" his/her age who you are familiar with. **Please circle <u>only</u> one number.**	
1	**Excellent** functioning / No impairment in settings.
2	**Good** functioning / Rarely shows impairment in settings.
3	**Mild** difficulty in functioning / Sometimes shows impairment in settings.
4	**Moderate** difficulty in functioning / Usually shows impairment in settings.
5	**Severe** difficulties in functioning / Most of the time shows impairment in settings.
6	**Needs considerable supervision** in **all** settings to prevent from hurting self or others.
7	**Needs 24-hour care and supervision** because of severe behavior or gross impairment(s).

Additional Comments:

Thank you for your time and effort on behalf of this child. Your perspective and information are essential for our evaluation and the family's understanding of their child's functioning. We look forward to working with you. Please feel free to contact us if there are any questions.

Parent and Teacher Developmental Assessment Questionnaires were developed by the Center for Children with Special Needs, New England Medical Center, Box #334, 750 Washington Street, Boston, MA 02111. (617) 636-7242.

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Child's Name:_____DOB:_____

Physician Form (revised 12-06)

We understand that you would like us to evaluate this patient and would appreciate the following information to help us with the assessment process. Thank you.

Date: _____ Physician Name: _____

Person completing form:_____

Office Address: _____
Street address City State Zip Code

Phone #: _____ Fax #: _____ Email: _____

- How long have you been the child's primary care provider? _____
- Please specify your questions and/or the type of evaluation(s) you would like for this child:
- What are your concerns about this child's development, behavior or emotional state?
- What aspects of social or family history should we know?
- What aspects of medical history should we know?
- Is the child currently on any regular medications? **No Yes**
  If **Yes**, please specify:

Sensory Testing	Date	Results
Vision Testing		
Hearing Testing		

You will receive a report after the evaluation is completed. Please contact us if you have any questions or further comments or would like to discuss this patient before the evaluation.

Thank you,
- The Staff of the Center for Children with Special Needs

Please complete and return this form as soon as possible to:
Bresnahan Miller Levy Sakai Ultmann von Hahn
Restrepo Alawami Pitterle Sukkarieh Other clinician:_____

Center for Children with Special Needs

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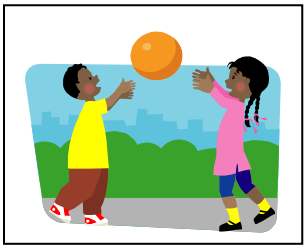

Observer's Report Form (UNDER 5 years) revised 7.26.16

This form can be used by family members, teachers, classroom aides, therapists, child care providers or other observers as needed. Your observations are useful in understanding this child's current functioning in a variety of settings.

Child's Name: _____Age:_____ Date:_____

Person(s) completing form:_____Relationship:_____

Address:_____ Phone:_____ Fax: _____

Setting:_____Time of day observed:_____

NOTE: Please attach reports, evaluations or current Individual Family Service Plans (IFSP) if any.

- Is this child receiving Special education services, Head Start, Early Intervention or private services? **No Yes**

  If yes, please describe services:

- Please describe your main CONCERNS at this time: (developmental skills, behavior, attention span, work habits, social skills, emotional responses, motor skills, academic readiness skills, etc.):

- Please comment on this child's significant STRENGTHS:

Continues on other side

- Please complete this survey comparing this child to children of the same age and sex.

Current Performance Survey	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
Overall developmental level?				
Language skills?				
Fine Motor skills?				
Gross Motor skills?				
Self-help skills?				
Pre-academic skills?				
Overall behavior?				
Attention span or distractibility?				
Activity level?				
Impulse control?				
Unusual behaviors?				
Aggression?				
Cooperation?				
Emotional functioning?				
Relationship with adults?				
Relationship with parents?				
Relationships with other children?				

Please comment on your responses in the space below.

- Does this child have any health problems or take any medications for chronic or acute health problems?

  __Don't know __ No __ Yes If yes please specify:

- Does this child take medications for emotional or behavioral problems, such as ADHD?

  __ Don't know __Never __Medication in past (please specify) __Current medication (please specify)

- Is there any other information about the child, the family, school setting or the situation that would be helpful?

- What do you think might help this child function better?

Thank you very much.

GUIDE TO ASSESSMENTS PROVIDED BY
THE CENTER FOR CHILDREN WITH SPECIAL NEEDS

(Please note, the CCSN serves children from birth to age 16.)

1. Developmental-Behavioral Pediatrician (DBP) Evaluation (Also called a Neurodevelopmental Evaluation) Assesses overall cognitive, social, emotional, educational, speech and motor development. Includes a brief physical exam with attention to neurological components.

When needed:

- To diagnose various types of developmental delays/disorders and make recommendations to a child's school and parents about how best to help the child progress.
- To help assess and develop a treatment plan for behavior problems in pre-schoolers or toddlers.
- To provide a developmental assessment of children/teens with a developmental disorder and related behavior or mood problems with recommendations for school and home.

Payment:

- Most major insurance companies cover this with proper referral by the PCP. If in doubt, check with your insurance company to see that they are contracted with Tufts Medical Center.

Formats:

- Children may be seen by a DBP for a straightforward evaluation, or in one of the following formats depending on the child's age, and/or concerns:
    - Multi-disciplinary clinics for children from birth up to 6 years old, staffed by DBP, Speech Pathologist and Clinical Social Worker. Involves 2 visits.
    - LEAP: Multidisciplinary team evaluation staffed by DBP, Clinical Social Worker, Psychology Intern) involves three visits for school age children with learning, behavioral and/or developmental issues.

2. Educational Evaluation is an in depth assessment of academic skills in reading, writing, spelling and mathematics.

When needed:

- To evaluate for suspected learning disabilities.
- To obtain detailed recommendations about the most appropriate educational programming for a child.
- To assess a child's academic progress and the appropriateness of their IEP.

Payment:

- No insurance will pay for this. It must be paid for by the parent or by the school system.
- If the student has had a TEAM evaluation within the past 16 months the parent has a right to request an Independent Educational Evaluation (IEE). If not, they can request that the school test the child, then request the IEE if not satisfied after the Team meeting.

3. Reading Disabilities Identification Clinic (RIC) is an assessment to identify children ages 4-6 who may be at risk for difficulty learning to read. Early identification and treatment are critical for such children.

When Needed:

- Delayed speech or language skills.
- Difficulty with early learning and remembering (names of colors, shapes, numbers, letters, people's names, days of the week, letters in own name)
- Difficulty with early phonics and reading skills (letter sounds, rhyming and blending sounds, remembering simple sight words, avoiding reading and writing)

Payment

- Same as for an Educational Evaluation

4. Classroom Observation

When Needed

- When there are questions about how a child's IEP is being implemented, or how a child is responding to the classroom environment.
- Generally recommended as accompaniment to an Educational Evaluation.
- Can be useful adjunct to Speech/Language Assessment to further assess pragmatics

Payment

- Same as for Educational Evaluation

5. Speech and Language Evaluation is an in depth evaluation of a child's expressive and receptive language abilities, their articulation of speech and their pragmatic communication skills.
When needed:
- If there is a S/L delay and the child hasn't had a thorough S/L evaluation in the past year.
- Especially useful with pre-school age kids if there is a question of autism.
- As part of an IEE for kids who have a suspected language-based learning disability.

Payment
- Covered by most all major health insurance plans, but parent should check with their insurance. Insurance will only cover one evaluation per year. A referral is usually needed from the PCP.

6. Neuropsychological testing is an in depth assessment of cognitive functioning including: verbal and nonverbal intelligence; how information is processed, stored (short and long term memory), and retrieved; visual motor integration ability; executive functioning abilities. It can include a screening of emotional functioning.
When Needed
- For independent evaluations to identify cognitive abilities and make recommendations for educational programming.
- To further assess when there are indications of problems with processing of information, memory, executive functioning, visual motor skills or cognitive delays.
- Useful for cases of physical illness or injury that may be impacting on cognitive functioning.

Payment
- For coverage by insurance, testing must be related to a medical or psychiatric concern. Testing for learning problems alone is not covered by insurance.
- May qualify for school payment as an Independent Educational Evaluation (See Educational Evaluation)

7. Social Work Intake involves a clinical social worker meeting with a parent (usually without the child) for up to 90 minutes for the purposes of: clarifying the concerns and obtaining relevant history of the child and family. The social worker obtains permission to contact relevant third parties, and gathers any additional needed records. A service plan is developed for the child at CCSN, and recommendations may be offered re: school, home and community services.
When Needed
- If there are indications of psychosocial stressors (i.e. mental health issues, DCF involvement, homelessness)
- If it is really not clear what the child needs from the CCSN and more history is needed.
- To provide triage and assistance while the family waits for other CCSN appointments
- If child is school age and will be seen as part of a LEAP evaluation.

Payment
- Check to see if insurance is in network with the medical center as a Behavioral Health Provider. This is billed as a Diagnostic Visit (Procedure code # 90791) with the medical center as the provider.