Name of person(s) completing form: _____ **Date completed:** ___/___/____

CHILD'S NAME:	**Last Name:**			**First Name:**	
Date of birth:	/ /	**Age:**		**❑ Male**	**❑ Female**
Parent 1 name / date of birth				/ /	
Parent 2 name / date of birth				/ /	
Home address:					
Phone numbers:	**H:**			**C:**	
Email:					
Second home address & phone: (specify parent):					
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):				
Who referred you to the CCSN?					

CHILD'S PRIMARY DOCTOR:		
Doctor's address & phone #:		**#:**
OTHER PHYSICIANS INVOLVED:		
❑ Neurologist:		**#:**
❑ Psychiatrist:		**#:**
❑ Developmental Behavioral Pediatrician:		**#:**

CURRENT SCHOOL/PROGRAM:		
School Address and number:		**#:**
Contact Person and number:		**#:**

PRIMARY HEALTH INSURANCE:	
Policy # for your child:	
If Masshealth, plan type:	❑ PCC/MBHP ❑ Neighborhood HP ❑ Network Health ❑ Fallon Community HP
***NOTE TO MASSHEALTH PATIENTS: BMC-Healthnet and CeltiCare do not cover services at the CCSN*.**	
Secondary Health Insurance:	
Do you have a letter from the school approving payment for an independent evaluation? ❑ Yes ❑ No If so, please include or fax to 617-636-5621. **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 1	Somewhat concerned 2	Very concerned 3	Extremely concerned 4
❑	Learning problems with reading, writing, spelling and/or math.	1	2	3	4
❑	Do not agree with the school over whether my child needs services, and/or what type of services are needed.	1	2	3	4
❑	Problems paying attention, staying focused, remembering or finishing tasks.	1	2	3	4

❑	Problems sitting still, being too active, talking too much, or acting without thinking.	**1**	**2**	**3**	**4**
❑	Behavioral problems (does not follow rules, acts defiant, aggressive or has melt downs).	**1**	**2**	**3**	**4**
❑	Emotional problems (is often unhappy, depressed, nervous, worried, irritable or angry).	**1**	**2**	**3**	**4**
❑	Problems making or keeping friends.	**1**	**2**	**3**	**4**
❑	Difficulty with speaking or communicating, or with understanding the speech and communication of others.	**1**	**2**	**3**	**4**
❑	Odd behaviors, body movements, and/or focusing on only certain topics or interests.	**1**	**2**	**3**	**4**
❑	Daily living skills (dressing, eating, toileting, etc)	**1**	**2**	**3**	**4**
❑	Mental abilities (thinking, understanding and/or solving problems) seem low for their age.	**1**	**2**	**3**	**4**
❑	Unusual sensitivity to noises, sensations, tastes, and/or smells that interferes with daily living.	**1**	**2**	**3**	**4**
❑	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?)	**1**	**2**	**3**	**4**

Please tell us more about your concerns (attach a separate sheet if needed):_____

_____

_____

_____

What are your child's strengths and interests? _____

_____

_____

_____

What do you hope to achieve during this visit? _____

_____

Has your child ever been diagnosed with a problem with his/her development, behavior, emotions or learning? ❑Yes ❑ No
If yes, describe: _____

_____

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? ❑ yes ❑ no Explain: _____

_____

_____

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.

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?) _____

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?) _____

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? ❑ yes ❑ no Explain:_____

Were there medical or other problems during the pregnancy or delivery (❑ fertility treatment ❑ infections (including herpes) ❑ unusual exposures)? Explain: _____

(Pregnancy, Labor and Delivery, cont.)

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:_____
- ❑ herbal remedies: _____
- ❑ over the counter medications: _____
- ❑ drank alcohol (e.g. wine, beer), ____ # drinks per day
- ❑ smoked cigarettes, _____ # packs per day
- ❑ drugs taken (e.g. marijuana, cocaine): _____

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? ❑ yes ❑ no If yes, describe: _____

_____

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? ❑ yes ❑ no If yes, describe:_____

_____

Did your child have feeding problems as a newborn or infant? ❑ yes ❑ no If yes, describe:_____

_____

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

Does your child have any allergies? ❑ yes ❑ no If yes, list:_____

D. Medication History

Does your child take:	**Current or past?**	**Which ones and why?**
Prescription medications? ❑ yes ❑ no Prescribed by:		
Over the counter medications (including vitamins)? ❑ yes ❑ no		
Other biomedical/complementary/ alternative treatments? ❑ yes ❑ no		

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: _____

Parents' marital status: ❑ Married ❑ Never married ❑ Separated / Divorced ❑ Widowed

Parent 1 Name: _____ Relationship to child: _____

When did your child begin to:	Age:	Not yet	When did your child begin to:	Age:	Not yet

Occupation: _____ Highest level of school completed: _____

Parent 2 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 If so, explain: _____

Has the child ever lived in an out-of-home placement? (e.g. foster care, residential center) ❑ yes ❑ no If so, explain:

_____

Are there family problems that may be bothering the child? (e.g. serious illness, family members with mental health problems, divorce, financial problems, housing problems) ❑ yes ❑ no If so, explain: _____

_____

Are there frequent arguments and/or physical abuse in the home? ❑ yes ❑ no If so, explain: _____

_____

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

_____

_____

Has your child ever lost skills? ❑ yes ❑ no If yes, when and what skills: _____

_____

_____

Please give us information on the following milestones:

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		❑

VII. SOCIAL, EMOTIONAL & BEHAVIORAL HISTORY

Please describe your child’s personality: _____

_____

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

Do you have concerns about your child’s <u>behavior</u> at: ❑home ❑ school ❑ in the community? If so, explain:

_____

_____

_____

Please indicate how often your child exhibits the following:	**Never**	**Some-times**	**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 <u>listen</u> 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				
Please indicate how often you child does the following:	**Never**	**Some-**	**Often**	**Very**

		times		Often
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				
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				
(OFFICE USE ONLY) 1-9: ____ **/** 9 (IA: ≥ 6 / 9) 10-18: ____ /9 (HI: ≥ 6/9) 19-26**:** ____ /8 (ODD: ≥4/8) 27-30 (CD) 31-37 (MDD) 35-44 (AD)				

VII. PRESCHOOL/SCHOOL HISTORY

Current grade: ____ Type of classroom: ❑ Regular ❑ Integrated ❑ Substantially Separate On an IEP? ❑ yes ❑ no

How satisfied are you with your child's <u>current</u> school placement? ❑ Very Satisfied ❑ Somewhat Satisfied ❑ Not Satisfied

_____

_____

Please tell us more about the services your child receives or has received at SCHOOL:	
❑ 504 Plan (Accommodations), At age:	❑ Applied Behavioral Analysis (ABA) (❑ current ❑past)
❑ IEP (Special Education), At age:	❑ Counseling at school (❑ current ❑past)
❑ School testing (CORE Evaluation), when?	❑ Failed a grade/class, which one?
❑ Physical therapy (❑ current ❑past)	❑ Been suspended or expelled, when?
❑ Speech therapy (❑ current ❑past)	❑ Repeated a grade, which one?
❑ Occupational therapy (❑ current ❑past)	❑ Other:

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:		

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)
- IMPORTANT: If you have legal guardianship for this child, please include a copy of the legal documentation

We look forward to working with you and your child.

For Office Use Only:	Reviewed by (Signature):
Date: Time:	Print Name: Credentials:

THE CENTER FOR CHILDREN WITH SPECIAL NEEDS
The Floating Hospital for Children
Tufts Medical Center
TWO-WAY RELEASE OF INFORMATION

PATIENT INFORMATION

Child's Name: _____ DOB: _____

Parent Name(s) _____

Street Address: _____

City/Town: _____

Telephone Numbers: Home: ( )_____ Work: ( ) _____

Insurance/HMO _____

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 me or 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 and fax.

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. 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 (PCP): Name:

Address: Telephone #

Other professionals involved (e.g. physician, therapist, social worker): Name:

Address: Telephone #:

School system: Name of Contact Person:

Address: Telephone #:

Signature Date Relationship to child

This Release is Valid for One year from Date of Signing

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.

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 von Hahn Ultmann Sakai Levy Lucarelli
Lau, Al-Jadiri, Walkowiak, Mulė, Reilly, Other_____

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Observer's Report Form (Five and above) (Revised 1-10-18)

This form can be used by family members, teachers, classroom aides, tutors, 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:____ Grade:____ Date:_____

Person(s) completing form:_____Relationship:_____

Address:_____Phone:_____Fax:_____

Setting:_____Time of day/period observed:_____

Service provided:_____

CURRENTMEDICATION(S): _____

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

2. Please comment on this child's significant STRENGTHS:

3. What do you think might help this child function better?

4. How does this child do academically or perform in your setting? Please note grades, level of functioning, or results of testing

Please indicate your estimate of this child's skill level below:

Subject	K	1	2	3	4	5	6	7	8	9	10	11	12
Reading													
Writing													
Math													
Other:													

Continued on other side *

5. 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:

6. Does this child take medications for Attention-Deficit/Hyperactivity Disorder, emotional or behavioral problems:
❒ Don't know ❒ Never ❒ Medication in past (please specify) ❒ Current medication (please specify)

A. In your opinion, how helpful is the current medication for ADHD, emotional or behavioral problems:
❒ Don't know ❒ Very helpful ❒ Somewhat helpful ❒ No change ❒ Somewhat worse ❒ Much worse

B. Do you have any concerns about the current medication, timing, doses or possible side effects?
❒ Don't know ❒ No ❒ Yes (please specify):

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

Current Performance Survey	**Not a Problem**	**Mild Problem**	**Moderate Problem**	**Severe Problem**
Overall academic achievement (skills)?				
Overall school performance (productivity, task completion)?				
Overall home performance (ability do tasks, homework)?				
Overall behavior?				
Overall emotional functioning?				
Relationships with adults?				
Relationships with other children?				

CAP Rating Scale (Compare to other children of same age and sex)		**Not True**		**Sometimes True**		**Often or Very True**	
1.	Fails to finish things he/she starts	0		1		2	
2.	Can't concentrate, can't pay attention for long	0		1		2	
3.	Daydreams or gets lost in his/her thoughts	0		1		2	
4.	Difficulty following directions	0		1		2	
5.	Messy work	0		1		2	
6.	Inattentive, easily distracted	0		1		2	
7.	Fails to carry out assigned tasks	0		1		2	
	Total:						
8.	Can't sit still or hyperactive	0		1		2	
9.	Fidgets and squirms	0		1		2	
10.	Impulsive or acts without thinking	0		1		2	
11.	Talks out of turn	0		1		2	
12.	Over reacts	0		1		2	
	Total:						

Medication status:
❒ On Medication
❒ No Medication
❒ Don't Know

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.