



# Parent Intake Questionnaire

## (Children 5 years and older)

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

### I. GENERAL INFORMATION

Person we should contact for appointment: \_\_\_\_\_ Phone: \_\_\_\_\_

#### Child

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Male  Female

#### Parents/Guardians

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Primary phone number: \_\_\_\_\_ Secondary phone number: \_\_\_\_\_

Email: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Primary phone number: \_\_\_\_\_ Secondary phone number: \_\_\_\_\_

Email: \_\_\_\_\_

Child's primary language: \_\_\_\_\_ Parent's primary language: \_\_\_\_\_

Interpreter needed?  Yes  No

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

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

Who referred you to the CCSN? \_\_\_\_\_

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

#### Child's Primary Doctor

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Indicate if your child has seen a:

Neurologist

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Psychiatrist:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Developmental Behavioral Pediatrician:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Payment Arrangements**

Primary Health Insurance: \_\_\_\_\_ Policy number: \_\_\_\_\_

Secondary Health Insurance: \_\_\_\_\_ Policy number: \_\_\_\_\_

For School Pay or Independent Educational Evaluations (IEE):

Do you have a letter from the school approving payment?  Yes  No

If so, please include or fax to 617-636-5621.

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

**II. PRESENTING CONCERNS**

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

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

*continued*

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

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What are your child's strengths and interests?

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

If yes, describe.  Yes  No

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

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

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

By whom: \_\_\_\_\_

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

By whom: \_\_\_\_\_

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

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

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**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?)

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

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**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?)

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

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

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

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

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

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

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

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

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

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

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

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**IV. MEDICAL INFORMATION**

Is this child adopted?  Yes  No At age \_\_\_\_\_ from (country) \_\_\_\_\_

**A. Pregnancy, Labor and Delivery History**

How many times has mother been pregnant? \_\_\_\_\_ How many children does mother have? \_\_\_\_\_

Birth order of this child? \_\_\_\_\_ Age of mother when this child was born? \_\_\_\_\_

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

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

Fertility treatment  Infections (including herpes)  Unusual exposures

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

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Were any of them abnormal? Explain:

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

prescription medications: \_\_\_\_\_

over the counter medications: \_\_\_\_\_  herbal remedies: \_\_\_\_\_

drank alcohol (e.g. wine, beer), \_\_\_\_\_ # drinks/day \_\_\_\_\_

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

**B. Birth History**

Baby was born at \_\_\_\_\_ weeks Birth weight? \_\_\_\_\_ lbs. \_\_\_\_\_ oz. Twin or triplet?  Yes  No  
 Mode of delivery:  Vaginal  Cesarean Section Were there problems? If yes, describe.  Yes  No

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

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

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

**C. Medical History (Review of Systems)**

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

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

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

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

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**D. Medication History**

Does your child take prescription medications?  Yes  No

Medication	Current or past?	Prescribed by	Why?

**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

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Parent Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Highest level of school completed: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Highest level of school completed: \_\_\_\_\_

Child's siblings or other children IN the home:	Full, half, adoptive, step, etc.	Age	Child's siblings NOT living in the home:	Full, half, adoptive, step, etc.	Age

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has the child had a very upsetting experience? (e.g. witnessed violence, physical or sexual abuse)  Yes  No  
 Has the child ever lived in an out-of-home placement? (e.g. foster care, residential center)  Yes  No  
 Are there frequent arguments and/or physical abuse in the home?  Yes  No  
 Are there family problems that may be bothering the child?  Yes  No  
*(e.g. serious illness, family members with mental health problems, divorce, financial problems, housing problems)*

## VI. DEVELOPMENTAL HISTORY

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

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

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

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

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

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

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

**VII. SOCIAL, EMOTIONAL & BEHAVIORAL HISTORY**

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

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

*continued*

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

**VIII. SCHOOL INFORMATION**

Current School Name: \_\_\_\_\_

School Address and number: \_\_\_\_\_ Grade: \_\_\_\_\_

Contact Person and number: \_\_\_\_\_ Grade: \_\_\_\_\_

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

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

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

Very Satisfied  Somewhat Satisfied  Not Satisfied

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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/#)
<input type="checkbox"/> Early Intervention, Why?		
<input type="checkbox"/> Social Worker / Case Manager		
<input type="checkbox"/> Speech and Language Therapy		
<input type="checkbox"/> Occupational Therapy		
<input type="checkbox"/> Physical Therapy		
<input type="checkbox"/> Tutoring		
<input type="checkbox"/> Applied Behavioral Analysis (ABA) Therapy		
<input type="checkbox"/> Mental Health Counseling (e.g. CBHI/in-home therapy, individual or family therapy)		
<input type="checkbox"/> Psychiatric or Drug Treatment Hospitalization		
<input type="checkbox"/> Department of Developmental Services (DDS)		
<input type="checkbox"/> Department of Mental Health (DMH)		
<input type="checkbox"/> Department of Children and Families (DCF)		
<input type="checkbox"/> Other:		

