CENTER FOR CHILDREN WITH SPECIAL NEEDS

Parent Intake Questionnaire
(Children younger than 5 years)

Tufts Children's Hospital

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

I. GENERAL INFORMATION

Person we should contact for appointment: _____ Phone: _____

Child

Last Name: _____ First Name: _____

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

Parents/Guardians

Name: _____ Address: _____

Primary phone number: _____ Secondary phone number: _____

Email: _____

Name: _____ Address: _____

Primary phone number: _____ Secondary phone number: _____

Email: _____

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

Interpreter needed? ☐ Yes ☐ No

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

_____

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

Who referred you to the CCSN? _____

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

continued

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 Arrangments

Primary Health Insurance: _____ Policy number: _____

Secondary Health Insurance: _____ Policy number: _____

For School Pay or Independent Educational Evaluations (IEE):

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

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

II. PRESENTING CONCERNS

Please describe your main concerns about your child:

_____

When did you first worry about these problems?

_____

What are your child's special qualities and strengths?

_____

continued

III. CHILD'S BIRTH HISTORY

Is this child adopted? ☐ Yes ☐ No

If yes, at age _____ months/years from (country): _____

Pregnancy, Labor and Delivery History

Age of mother when child was born: _____ years. Baby was born at _____ weeks.

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

continued

Newborn History

Birth weight? _____ lbs. _____ oz.

Newborn History	Yes	No	Comments
1. Were there any problems at birth or as a newborn?			
2. Were any birth defects or birth injuries noted?			
3. Put in Special Care or Intensive Care Nursery? For how many days?			
4. Have jaundice and need phototherapy?			
5. Very jittery or lethargic as a newborn?			
6. Baby had to stay extra days in the hospital? For how many days?			
7. Any problem with blood pressure or toxemia?			
8. Any problems with infections (including herpes)?			
9. Smoking during pregnancy? How many packs per day?			
10. Drank alcohol (beer, wine, etc) during pregnancy?			
11. Any street drugs (marijuana, cocaine, etc.) used?			
12. Any problems during labor or delivery?			
13. Cesarean delivery? Why?			

continued

IV. MEDICAL INFORMATION

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? If yes, list. ☐ Yes ☐ No

_____

_____

_____

continued

V. CHILD'S CURRENT PRESENTATION

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				

Describe your child's temperament or personality.

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

How does your child get along with siblings?

_____

_____

_____

How does your child get along with playmates/peers?

_____

_____

_____

continued

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 usually 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 ☐ Never

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

   ☐ Plays 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

continued

Please answer these questions about your child and keep in mind how he/she usually behaves:	**Yes**	**No**
1. If you point at something across the room, does your child look at it?		
2. Have you ever wondered if your child might be deaf?		
3. Does your child play pretend or make-believe?		
4. Does your child like climbing on things?		
5. Does your child make unusual finger movements near his or her eyes?		
6. Does your child point with one finger to ask for something or to get help?		
7. Does your child point with one finger to show you something interesting?		
8. Is your child interested in other children?		
9. Does your child show you things by bringing them to you or holding them up for you to see?—not to get help, but just to share		
10. Does your child respond when you call his or her name?		
11. When you smile at you child, does he or she smile back?		
12. Does your child get upset by everyday noises?		
13. Does your child walk?		
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?		
15. Does your child try to copy what you do?		
16. If you turn your head to look at something, does your child look around to see what you are looking at?		
17. Does your child try to get you to watch him or her?		
18. Does your child understand when you tell him or her to do something?		
19. If something new happens, does your child look at your face and see how you feel about it?		
20. Does your child like movement activities? (i.e. being swung or bounced on your knee)		

VI. CHILD'S DEVELOPMENTAL HISTORY

Did your child seem to develop normally but then lose developmental skills? ☐ Yes ☐ No

If yes,describe: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

continued

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?			

continued

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

The following questions are about your child's sensory experiences.	**Never**	**Sometimes**	**Often**	**Very Often**
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.				
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.				
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				

continued

The following questions are about your child's ability to follow rules and routines. Please answer how often your child...				
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				

VIII. FAMILY AND SOCIAL HISTORY

Who does the child live with most of the time? ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather

☐ Adoptive Mother ☐ Adoptive Father ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle

☐ Foster parent ☐ Group Home ☐ Brother(s) ☐ Sister(s) ☐ Cousin(s) ☐ Other

_____

Parent Name: _____ Relationship to child: _____

Occupation: _____ Highest level of school completed: _____

Parent Name: _____ Relationship to child: _____

Occupation: _____ Highest level of school completed: _____

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

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

continued

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

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

Stressful Life Experiences	**Yes**	**No**	**Comments**
1. Child had a very upsetting experience (e.g. witnessed violence, physical abuse, sexual abuse, severe accident)?			
2. Moved? How many 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?			
7. Serious physical illness in parent, caregiver or sibling?			
8. Serious money or housing problems?			
9. Concerns about safety in neighborhood?			
10. Are there guns in the house?			

continued

IX. CHILD'S SERVICES HISTORY

	# days/ week	# min/ session
1. **Early Intervention Program (0 to 3 years)? Agency:**		
2. Developmental specialist:		
3. Speech/Language Therapy		
4. Occupational Therapy?		
5. Physical Therapy?		
6. Play Group		
7. Behavior Therapy (also known as ABA or Floortime)?		
8. **Day Care:** Name: _____ Teacher: _____		
9. Pre-school: Name: _____ Teacher: _____ School district: _____ Has your child been evaluated for special education? ☐ Yes ☐ No *If your child is on an IEP please include a copy with intake materials.*		

X. 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

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

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

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

We look forward to working with you and your child.