

Welcome to the Developmental Medicine Center at Boston Children's Hospital

Thank you for your interest in the Developmental Medicine Center (DMC). We provide:

- High quality diagnostic and follow-up care for children with developmental concerns and their families such as:
 - Autism Spectrum Disorders
 - Attention Disorders (ADD/ADHD)
 - Developmental Delays
- Initial appointments may be with one of the following providers or team of providers:
 - Developmental Pediatrician
 - Nurse Practitioner
 - Psychologist
- Resource Specialists: dedicated staff who provide outreach and education

The below steps will need to be completed prior to adding your child to the waitlist:

1. **Complete and return all** attached forms to our office by mail, email or fax. **Please do not send your original forms. We encourage you to make copies of all information for your records.**

Mail: Boston Children's Hospital
Developmental Medicine Center-Fegan 10
Attn.: Intake Coordinators
300 Longwood Avenue
Boston, MA 02115

Email: DMCIntake@childrens.harvard.edu
Fax: 617-730-0252

2. Please include copies of any recent documents from early intervention, school or outside providers such as:
 - **IFSP** (Individualized Family Service Plan-report from early intervention services)
 - **IEP** (Individualized Education Program)/**504 Accommodation Plan**
 - School district based **CORE/TEAM evaluations** (educational testing, psychological testing, OT, PT, and/or speech and language evaluations).
 - Any **private or clinic-based testing** (psychological testing, neuropsychological evaluation, OT, PT and/or speech and language evaluations).
3. Once all of this information has been received, **we will call to confirm and provide an estimate of your current wait time** for your initial visit.

The Developmental Medicine Center does not provide evaluations for child abuse and neglect, custody determination, immediate sociality, IQ testing for gifted placement, or assessment for acute psychiatric conditions. If you need any of the above services, please let us know and we can direct you to an appropriate provider.

If you need further information or have any additional questions, please feel free to contact the Center at 617-355-7025.

Thank you,

Lisa Prock, MD, MPH
Director
Developmental Medicine Center

Elaine LeClair, PhD
Director, Pediatric Psychology
Developmental Medicine Center

Insurance Information

Please fill out the below form with accurate information regarding your child's insurance plan(s). This information can be found on the insurance card, or by contacting your insurance company's member service number.

Most insurance companies require prior authorization for neuropsychological or psychological testing and/or mental health visits. Prior authorization is not a guarantee of payment coverage. Many insurers contract with a specific "carve-out" company to administer behavioral/mental health benefits and claims. If your insurer has such a "carve-out," the process for coverage determination and prior approval may be different from those processes used for you medical insurance benefits.

Please call your insurance company to inquire about coverage/benefits under your plan and your required out-of-pocket payments. Coverage policies for individual carriers differ greatly and change frequently.

Parent Name: _____

Primary Insurance Carrier: _____

Group name & number (if applicable): _____

Patient name: _____

Date of birth: _____

Child's identification number: _____

Effective from _____ to _____ (mm/dd/yyyy)

Subscriber's name & date of birth: _____

Subscriber's address (if different than child's address): _____

Important Member service phone number for mental health benefits (usually located on back of insurance card): _____

Secondary Insurance Carrier (if applicable): _____

Group name & number (if applicable): _____

Patient name: _____

Date of birth: _____

Child's identification number: _____

Effective from _____ to _____ (mm/dd/yyyy)

Subscriber's name & date of birth: _____

Subscriber's address (if different than child's address): _____

Important Member service phone number for mental health benefits (usually located on back of insurance card): _____

Your signature below indicates that you have been advised that you may be responsible for paying all charges associated with the visit.

I acknowledge that is any of the above referenced items or services is not considered medically necessary by my insurance company or is a non-covered service, I am financially responsible for the full amount should the claim be denied. If I am denied insurance coverage for any service, discounts may be available.

Guarantor Name: _____

Parent/Guarantor Signature: _____ **Date:** _____

A. GENERAL INFORMATION

Child's Name: *Last _____ *First _____
 *Date of Birth: _____ *Gender: M F Other
 Current Grade & School Name (if applicable): _____
 *Person completing questionnaire: _____

URGENT CONCERNS

Please **CHECK** any applicable boxes if you have urgent medical concerns.

MEDICAL:

- Seizures
- Loss of skills/developmental regression
- Loss of hearing
- Loss of vision
- Difficulty swallowing or choking
- Severe weakness or lack of coordination
- Inability to tolerate exercise
- Severe headache
- Other (please describe): _____

BEHAVIORAL / PSYCHIATRIC

- Suicidal thinking or attempt of child
 - Safety of any family members (including this child)
- Please explain:

**** Please understand that the Developmental Medicine Center has a waiting list. Because some problems need more urgent attention, if your child has any of the above problems, please also contact your pediatrician while you are waiting for your appointment.*

Please list the question(s) you would like answered by this evaluation (*at least one **REQUIRED**)

1. _____
2. _____
3. _____
4. _____

Who referred your child to the Developmental Medicine Center? (If a provider, please list name and specialty)	
Patient's Primary Care Provider (e.g. pediatrician, nurse practitioner):	
Date of last physical exam:	
Has your child been seen in the Developmental Medicine Center before?	<input type="checkbox"/> Y <input type="checkbox"/> N If yes, when?
	Was this for: <input type="checkbox"/> a team visit <input type="checkbox"/> an appointment with a single provider

*What languages are spoken in the home?	
*Where does the child live?	<input type="checkbox"/> at home <input type="checkbox"/> away from home at residential facility or school
*Does your child require an interpreter to do the testing?	<input type="checkbox"/> Y <input type="checkbox"/> N
*Does the parent/guardian require an interpreter for the visit?	<input type="checkbox"/> Y <input type="checkbox"/> N

***Do any of the following apply to this child?**

DCF (formerly DSS) involvement	<input type="checkbox"/> Y <input type="checkbox"/> N
DDS (formerly DMR) involvement	<input type="checkbox"/> Y <input type="checkbox"/> N
Lives in residential facility	<input type="checkbox"/> Y <input type="checkbox"/> N

B. CONTACT / DEMOGRAPHIC INFORMATION

***Parent/Caregiver 1 information**

Full Name: Last First

Relationship to child: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Telephone (check preferred number): home work mobile

Email Address: _____

Occupation: _____

Are you the legal guardian of the child? Y N Do you have physical custody of child? Y N

Parent/Caregiver 2 information

Full Name: Last First

Relationship to child: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Telephone (check preferred number): home work mobile

Email Address: _____

Occupation: _____

Are you the legal guardian of the child? Y N Do you have physical custody of child? Y N

Legal Guardian information (if different from above)

Full Name: Last First

Relationship to child: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Telephone (check preferred number): home work mobile

Email Address: _____

Occupation: _____

Are you the legal guardian of the child? Y N Do you have physical custody of child? Y N

C. SERVICES

CHECK if any of the following have previously or currently applies to your child

Check here if your child is not yet in child care or school, and skip this table

Early Intervention	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Individualized Family Service Plan (IFSP)	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
School (TEAM, CORE) evaluation <i>If yes, when?</i>	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Has/does your child have an Individualized Education Plan (IEP)? <i>If yes, date?</i>	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
504 Plan <i>If yes, date?</i>	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Attends a special needs daycare/preschool	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Receiving <input type="checkbox"/> speech <input type="checkbox"/> occupational <input type="checkbox"/> physical therapy	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Participates in Summer School or Extended School Year (ESY) services	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Psychological testing? <i>If yes, date?</i>	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Mental health counseling or behavioral therapy? <i>If yes, date?</i>	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
School disciplinary actions, including detention, suspension or expulsion? <i>If yes, specify & date?</i>	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Stay in psychiatric hospital	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N

****Please submit copies of the most recent Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP), and results of any previous academic, psychological, or school testing from the past 3 years.**

This information may be necessary for the Developmental Medicine Center to get authorization from your insurance company.

D. CONCERNS YOU HAVE ABOUT YOUR CHILD'S DEVELOPMENT OR BEHAVIORS

*Please check **any concerns you have** about your child:

<input type="checkbox"/> Autism Spectrum Disorder (Asperger's, Autism, PDD)	<input type="checkbox"/> Intellectual disability (formerly mental retardation)	<input type="checkbox"/> Tics/Tourette's
<input type="checkbox"/> Attention problems (ADHD, ADD)	<input type="checkbox"/> Speech/language delay	<input type="checkbox"/> Toileting problem (toilet training, bedwetting, soiling)
<input type="checkbox"/> Behavior problems	<input type="checkbox"/> Communication problems	<input type="checkbox"/> Genetic or chromosomal condition
<input type="checkbox"/> Developmental delay	<input type="checkbox"/> Fine motor problem	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Emotional or psychiatric problems	<input type="checkbox"/> Gross motor problem	<input type="checkbox"/> Obsessive-compulsive disorder (OCD)
<input type="checkbox"/> Learning problem	<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Bipolar disorder or mood swings
<input type="checkbox"/> Social Skills	<input type="checkbox"/> Problems with coordination	<input type="checkbox"/> Depression
<input type="checkbox"/> Mood	<input type="checkbox"/> Ataxia	<input type="checkbox"/> PTSD
	<input type="checkbox"/> Severe weakness or inability to tolerate exercise	<input type="checkbox"/> Substance use or abuse

E. CHILD'S MEDICAL HISTORY

Check if child's entire medical history is unknown – and answer as you are able.

Please check any conditions your child has been **diagnosed** with:

<p>Developmental Problems:</p> <input type="checkbox"/> Speech delay <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Behavior problems <input type="checkbox"/> Autism <input type="checkbox"/> Attention problems (ADD/ADHD) <input type="checkbox"/> Learning problems	<p>Mental Health Problems:</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Mood Disorder (Depression, Bipolar, Suicide thoughts or attempts) <input type="checkbox"/> Psychosis or Schizophrenia <input type="checkbox"/> Child has had a stay in a psychiatric hospital *If yes, when/where?
<p>Neurological Problems:</p> <input type="checkbox"/> Epilepsy/seizures <input type="checkbox"/> Sleep problems <input type="checkbox"/> Head injury <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tics or Tourette <input type="checkbox"/> Motor delays <input type="checkbox"/> Hearing problems <input type="checkbox"/> Vision problems <input type="checkbox"/> Headaches	<p>Genetic Disorders:</p> <input type="checkbox"/> Down Syndrome/trisomy 21 <input type="checkbox"/> Other chromosomal abnormalities <input type="checkbox"/> Metabolic disorder
<p>General Medical Problems:</p> <input type="checkbox"/> Heart disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart murmur <input type="checkbox"/> Thyroid <input type="checkbox"/> Congenital heart problem <input type="checkbox"/> Kidney/urinary problems <input type="checkbox"/> Overweight/Obesity <input type="checkbox"/> Cancer <input type="checkbox"/> Growth problems <input type="checkbox"/> Gastrointestinal problems (vomiting, feeding problems, abdominal pain, reflux, constipation, diarrhea) <input type="checkbox"/> Underweight/Failure to thrive <input type="checkbox"/> Allergies <input type="checkbox"/> Skin problems (rashes, eczema) <input type="checkbox"/> Respiratory (asthma, pneumonia)	<p>Surgical History: Has your child ever had any surgeries? If yes, please list below:</p> <hr/> <p>Any other specific medical concerns?</p>

Has the child ever had any of the following screening/ diagnostic tests or procedures?	If yes, when, where, and results? (Please send in copies of results if available)
Genetic and/or metabolic testing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Don't know
EEG	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Don't know
CT scan or MRI of the head	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Don't know
Sleep study	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Don't know
Hearing test	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Don't know
Vision test	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Don't know

***Review of Systems**

<p>General/constitutional:</p> <input type="checkbox"/> Significant behavioral changes <input type="checkbox"/> Significant weight loss or gain <input type="checkbox"/> Weakness or fatigue <input type="checkbox"/> Fever or chills	<p>Allergy:</p> <input type="checkbox"/> Itchy or watery eyes <input type="checkbox"/> Itchy or runny nose, sneezing <input type="checkbox"/> Hives <input type="checkbox"/> Needed to use Epi-Pen
<p>Gastrointestinal:</p> <input type="checkbox"/> Changes in appetite <input type="checkbox"/> Abdominal pain or discomfort <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloating, indigestion <input type="checkbox"/> Nausea, vomiting <input type="checkbox"/> Change in bowel habits (number/consistency) <input type="checkbox"/> Blood in stool <input type="checkbox"/> Jaundice (yellow skin or eyes), itching	<p>Neurological:</p> <input type="checkbox"/> Headaches <input type="checkbox"/> Sleep problems <input type="checkbox"/> Dizziness, vertigo <input type="checkbox"/> Fainting, blackouts <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness, tingling <input type="checkbox"/> Seizures, convulsions <input type="checkbox"/> Head injuries, concussions <input type="checkbox"/> Trouble walking <input type="checkbox"/> Tremor, unusual motor movement (tics) <input type="checkbox"/> Problems with coordination <input type="checkbox"/> Problems with concentration, memory

***Review of Systems (continued)**

<p>Heart:</p> <input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Heart racing, skipped beats <input type="checkbox"/> Ankle swelling, cold/blue hands, feet <input type="checkbox"/> Fainting, fatigue with exercise	<p>Lungs:</p> <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath, wheezing <input type="checkbox"/> Recent chest X-ray
<p>Eyes, Ears, Nose, Throat:</p> <input type="checkbox"/> Sore throats <input type="checkbox"/> Ear infections <input type="checkbox"/> Sinus infections <input type="checkbox"/> Loud snoring, irregular breathing during sleep <input type="checkbox"/> Problems with eyes/vision <input type="checkbox"/> Problems with ears/hearing	<p>Bones, joints, and muscles:</p> <input type="checkbox"/> Joint pain, stiffness, swelling <input type="checkbox"/> Fingers painful/blue in cold <input type="checkbox"/> Dry mouth, red eyes <input type="checkbox"/> Back, neck pain <input type="checkbox"/> Muscle problems <input type="checkbox"/> Fractures, broken bones <input type="checkbox"/> Sprains
<p>Endocrine:</p> <input type="checkbox"/> Sweating <input type="checkbox"/> Fatigue <input type="checkbox"/> Hand trembling <input type="checkbox"/> Neck swelling <input type="checkbox"/> Skin, hair, voice changes <input type="checkbox"/> Thirst <input type="checkbox"/> Growth difficulties	<p>Genitourinary:</p> <input type="checkbox"/> Nighttime bedwetting <input type="checkbox"/> Daytime urine accidents <input type="checkbox"/> Pain with urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Genital rashes or lumps <input type="checkbox"/> Heavy or painful menses (periods)
<p>Skin:</p> <input type="checkbox"/> Rashes <input type="checkbox"/> Changes in mole or spot <input type="checkbox"/> Needed stitches	<p>Hematologic:</p> <input type="checkbox"/> Bruise easily, difficulty stopping bleeding <input type="checkbox"/> Lumps under arms or on neck

F. CHILD'S BIRTH HISTORY

Check if birth history is unknown

Age of mother at delivery: _____

Age of father at delivery: _____

Number of previous pregnancies (including miscarriages or terminations): _____

During pregnancy, did the mother:

Take prenatal vitamins	<input type="checkbox"/> Y <input type="checkbox"/> N
Use tobacco	<input type="checkbox"/> Y <input type="checkbox"/> N If yes: how much?
Drink alcohol	<input type="checkbox"/> Y <input type="checkbox"/> N If yes: how much?
Take drugs or medications	<input type="checkbox"/> Y <input type="checkbox"/> N If yes: what drug(s) or medication(s), and during which trimester(s):

Birth Measurements:	Weight:	Height:	Head Circumference:
APGAR score (if known):	1 minute:	5 minute:	
Was the baby born at term?	<input type="checkbox"/> Y <input type="checkbox"/> N or numbers of weeks gestation at birth:		
What was the delivery method?	<input type="checkbox"/> vaginal <input type="checkbox"/> cesarean (C-section)		
<i>If cesarean, please describe why:</i>			
Were there any prenatal or neonatal complications?	<input type="checkbox"/> Y <input type="checkbox"/> N		
<i>If yes, please describe:</i>			
Was a NICU or extended hospital stay required?	<input type="checkbox"/> Y <input type="checkbox"/> N		
<i>If yes, please describe:</i>			

G. CHILD'S DEVELOPMENTAL HISTORY

As best as you can remember, list the age or check off the approximate time at which your child reached the following developmental milestones.

Developmental Skill	Age (if known)	Not yet	Only if exact age cannot be recalled		
			Early	At Normal Time	Late
Sat without support		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawled		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stood without support		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walked without assistance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spoke first words		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Said phrases		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Said sentences		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel trained		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder trained, day		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder trained, night		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

****Please submit copies of the most recent Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP), and results of any previous academic, psychological, or school testing from the past 3 years. This information may be necessary for the Developmental Medicine Center to get authorization from your insurance company.**

PLEASE FEEL FREE TO ATTACH ANY ADDITIONAL INFORMATION THAT YOU THINK MIGHT HELP US BETTER UNDERSTAND YOUR CHILD.

*Parent/Guardian Signature

*Print Name

*Date

*Relationship to patient

EARLY CHILDHOOD SCREENING ASSESSMENT:

Check the column that best describes this child compared to other children the same age. For each item, please check if you are concerned.

	Rarely/ Not True	Sometimes/ Sort of	Almost always/ Very True	Concerned?
1. Seems sad, cries a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is difficult to comfort when hurt or distressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Loses temper too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Avoids situations that remind him/her of scary events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is easily distracted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Hurts others on purpose (biting, hitting, kicking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Doesn't seem to listen to adults talking to him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Battles over food and eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is irritable, easily annoyed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Argues with adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Breaks things during tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Is easily startled or scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Tries to annoy people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Has trouble interacting with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Fidgets, can't sit quietly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Is clingy, doesn't want to separate from parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Is very scared of certain things (needles, insects)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Seems nervous or worries a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Blames other people for mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Sometimes freezes or looks very still when scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Avoids foods that specific feelings or tastes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Is too interested in sexual play or body parts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Runs around in settings when should sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Has a hard time paying attention to tasks or activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Interrupts frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Is always "on the go"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Reacts too emotionally to small things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Is very disobedient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Has more picky eating than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Has unusual repetitive behaviors (rocking, flapping)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Might wander off if not supervised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Has a hard time falling asleep or staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Doesn't seem to have much fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Is too friendly with strangers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Has more trouble talking or learning to talk than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Is learning or developing more slowly than other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you concerned about this child's emotional or behavioral development (please only circle one)?	<input type="checkbox"/> Yes	<input type="checkbox"/> Somewhat	<input type="checkbox"/> No	

Please tell us how much of a problem each one has been for you. For each item, please check if you are concerned.

	Rarely/ Not True	Sometimes/ Sort of	Almost always/ Very True	Concerned?
I feel too stressed to enjoy my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get more frustrated than I want to with my child's behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please summarize this child's OVERALL FUNCTIONING (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing ONE option below. Compare this child's functioning in child care/school and with peers to "average children" his/her age that you are familiar with from you experience.

Please circle only one number.

<input type="checkbox"/>	Excellent functioning/No impairment in settings
<input type="checkbox"/>	Good functioning /Rarely shows impairment in settings
<input type="checkbox"/>	Mild difficulty in functioning/Sometimes shows impairment in settings
<input type="checkbox"/>	Moderate difficulty in functioning/Usually shows impairment in settings
<input type="checkbox"/>	Severe difficulties in functioning/Most of the time show impairment in settings
<input type="checkbox"/>	Needs considerable supervision in all settings to prevent from hurting self or others
<input type="checkbox"/>	Needs 24-hour professional care and supervision due to severe behavior or gross impairment(s)

Have there been any other recent changes in your child's physical, emotional, psychological, or behavioral health that you are concerned about? Please describe:

*Parent/Guardian Signature

*Print Name

*Date

*Relationship to patient



Child's name _____
Age _____

Date _____
Relationship to child _____

M-CHAT-R™ (Modified Checklist for Autism in Toddlers Revised)

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please check **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?) Yes No
2. Have you ever wondered if your child might be deaf? Yes No
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?) Yes No
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs) Yes No
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?) Yes No
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach) Yes No
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road) Yes No
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?) Yes No
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? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck) Yes No
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?) Yes No
11. When you smile at your child, does he or she smile back at you? Yes No
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?) Yes No
13. Does your child walk? Yes No
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? Yes No
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do) Yes No
16. If you turn your head to look at something, does your child look around to see what you are looking at? Yes No
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say “look” or “watch me”?) Yes No
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand “put the book on the chair” or “bring me the blanket”?) Yes No
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?) Yes No
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee) Yes No

Early Childhood Educational Questionnaire

Child's Name: *Last _____ *First _____
*Date of Birth: _____ *Gender: M F Other
Child' classroom/age level: _____

Please have early intervention, child care and/or school personnel fill out and return

Child Care/School: _____

Child Care/School address: _____

Form completed by: _____ Position: _____

With help from: _____

Contact Person: _____

Phone number and best time to call: _____

Email address _____

List up to 3 specific questions you would like answered as a result of this evaluation that would help you better meet this child's developmental and educational needs

1. _____

2. _____

3. _____

In your opinion, what areas of this child's functioning need the improvement?

Please describe the child's strengths.

Please describe any other concerns you have about this child.

Besides English, are there any additional languages used for the child's instruction? Y N

If yes, what language? _____

ACADEMIC READINESS: Please check the appropriate column

	Not Yet	Progressing	Proficient
A. Basic Concepts			
1. Knows colors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Knows letters of alphabet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Knows numbers and counts past 10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Adds and subtracts things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Size concepts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Location concepts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Language and Communication			
1. Uses speech to communicate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Explains and describes things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Rhymes words and remembers poems/songs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Uses uncommon words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Uses long sentences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Tells or retells stories or events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Speaks understandably	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Follows oral instructions on level with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Uses correct grammar (e.g. verb tense)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Uses sign language or other communication system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Follows classroom routine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Emergent Literacy			
1. Listens to stories in books	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Asks questions about words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Reads words on signs and labels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Reads words in books	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Recites books from memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Reads "easy" books	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Writes or copies words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Dictates stories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Writes "little" stories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Answers questions about orally read story	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Motor Skills			
1. Constructs puzzles or builds things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Uses pencils and pens correctly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Uses scissors well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Copies and traces shapes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Draws recognizable objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is coordinated in outdoor recess activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Ties shoe laces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EARLY CHILDHOOD SCREENING ASSESSMENT:

Please check the column that best describes this child compared to other children the same age. For each item, please check if you are concerned.

	Rarely/ Not True	Sometimes/ Sort of	Almost always/ Very True	Concerned?
1. Seems sad, cries a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is difficult to comfort when hurt or distressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Loses temper too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Avoids situations that remind him/her of scary events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is easily distracted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Hurts others on purpose (biting, hitting, kicking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Doesn't seem to listen to adults talking to him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Battles over food and eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is irritable, easily annoyed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Argues with adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Breaks things during tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Is easily startled or scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Tries to annoy people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Has trouble interacting with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Fidgets, can't sit quietly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Is clingy, doesn't want to separate from parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Is very scared of certain things (needles, insects)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Seems nervous or worries a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Blames other people for mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Sometimes freezes or looks very still when scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Avoids foods with specific textures or tastes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Is too interested in sexual play or body parts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Runs around in settings when should sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Has a hard time paying attention to tasks or activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Interrupts frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Is always "on the go"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Reacts too emotionally to small things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Is very disobedient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Has more picky eating than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Has unusual repetitive behaviors (rocking, flapping)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Might wander off if not supervised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Has a hard time falling asleep or staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Doesn't seem to have much fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Is too friendly with strangers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Has more trouble talking or learning to talk than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Is learning or developing more slowly than other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you concerned about this child's emotional or behavioral development (please only circle one)?	<input type="checkbox"/> Yes	<input type="checkbox"/> Somewhat	<input type="checkbox"/> No	

Please summarize this child's OVERALL FUNCTIONING (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing ONE option below. Compare this child's functioning in child care/school and with peers to "average children" his/her age that you are familiar with from you experience.

Please circle only one number.

<input type="checkbox"/>	Excellent functioning/No impairment in settings
<input type="checkbox"/>	Good functioning /Rarely shows impairment in settings
<input type="checkbox"/>	Mild difficulty in functioning/Sometimes shows impairment in settings
<input type="checkbox"/>	Moderate difficulty in functioning/Usually shows impairment in settings
<input type="checkbox"/>	Severe difficulties in functioning/Most of the time show impairment in settings
<input type="checkbox"/>	Needs considerable supervision in all settings to prevent from hurting self or others
<input type="checkbox"/>	Needs 24-hour <u>professional</u> care and supervision due to severe behavior or gross impairment(s)

Please describe this child's social-emotional functioning, including moods and relationship with peers.

Please describe this child's behavior.

Is there any other information you think would be helpful for evaluating this child?

*Teacher Signature

*Print Name

*Date