Boston Children's Hospital | Autism Spectrum Center
Until every child is well™

Welcome to the Autism Spectrum Center at Boston Children's Hospital

Thank you for your interest in the Autism Spectrum Center (ASC). We provide:

- Comprehensive, family-centered diagnostic and care services for children with autism spectrum disorder
- Initial appointment may be with **one** of the following providers:
  - Developmental Pediatrician
  - Neurologist
  - 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
   Autism Spectrum Center BCH3433
   Attn.: Intake Coordinators
   300 Longwood Avenue
   Boston, MA 02115

   Email: AutismCenter@childrens.harvard.edu

   Fax: 617-730-4823

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 Autism Spectrum Center does not provide evaluations for child abuse and neglect, custody determination, immediate suicidality, 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 by phone at 617-355-7493 or by email at AutismCenter@childrens.harvard.edu. You can also visit our website: www.bostonchildrens.org/autismspectrumcenter

Family Education Sheet

Preparing for a Medical Appointment or Autism Spectrum Disorder (ASD) Evaluation

Boston Children's Hospital Autism Spectrum Center

childrenshospital.org/autismspectrumcenter

Whether you are coming to Boston Children's Hospital for an outpatient appointment, evaluation, a surgical procedure or an emergency visit, there are steps you can take to create a more positive experience for your child.

What should I bring?

Communication systems and devices

- **Bring your child's communication system or device** (for example: Dynavox, picture communication board, or iPad/tablet) to the appointment.
    - Even if your child can speak, the stress of a hospital visit can make it hard to communicate. Having these systems with you helps to make sure that your child can communicate with their medical team.

Distraction tools

Distraction items can help your child cope with a medical appointment.

- **Bring a favorite toy, sensory item, book or electronic device** (iPad or tablet)
- **Bring a set of headphones.** Headphones may be good for your child to wear if you are going to talk about sensitive issues with the health care provider.

Rewards or reinforcers

- **Bring items that you often use as rewards for your child in your home.** For example, if your child struggles with blood draws, it can be helpful to say "First blood draw, then a sticker."

Comfort items

If your child has favorite stuffed animal, blanket, or object, you can bring it. It may help to make the visit or stay more comfortable.

How can I prepare my child?

My Hospital Stories

- These are visual tools that give your child a sense of what may happen, what the hospital area may look like and what to expect.
- You can find My Hospital Stories here: http://www.childrenshospital.org/patient-resources/family-resources/child-life-specialists/preparing-your-child-and-family-for-a-visit/my-hospital-story.

Medication

Please give your child their medication as you normally would unless you are told otherwise by your provider's team.

Behavior support plan

- If your child often has a hard time with medical visits, you can **work with our team to develop a behavior support plan.** Call the Autism Spectrum Center at 617-355-7493 for help creating this plan.
- This plan will alert staff to your child's unique needs and preferences, including help with getting to a clinic, limiting the number of people in the room or providing distraction tools.

Child Life specialists

- Child Life Specialists use developmentally appropriate strategies and play to help support your child through medical procedures. The Autism Spectrum Center's Child Life Specialist can work with you to plan ahead for your visits, prepare for appointments and provide support on the day of the appointment.
- For more information, contact the Autism Spectrum Center's Child Life Specialist at 617-919-6390 or by e-mail at kristin.coffey@childrens.harvard.edu.

How can *I* prepare?

- Write down your questions and concerns **before** the visit to share with your child's provider.
- Give yourself more time than you think you need to get to the appointment.
- Ask for help if your child is having a difficult time—many departments or areas are able to offer accommodations.
- If possible, bring someone with you for support

This Family Education Sheet is available in Spanish.

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 your 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:** _____

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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 any of the following urgent 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 Autism Spectrum 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 Autism Spectrum Center? (If a provider, please list name and specialty)	
Patient's Primary Care Provider (i.e. pediatrician, nurse practitioner):	
Date of last physical exam:	
Has your child been seen in the Autism Spectrum Center before?	☐ Y ☐ N If yes, when?
	Was this for: ☐ a team visit ☐ an appointment with a single provider

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

*__Do any of the following apply to this child?__

DCF (formerly DSS) involvement	☐ Y ☐ N
DDS (formerly DMR) involvement	☐ Y ☐ N
Lives in residential facility	☐ Y ☐ 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	☐ Y, in the past	☐ Y, current	☐ N
Individualized Family Service Plan (IFSP)	☐ Y, in the past	☐ Y, current	☐ N
School (TEAM, CORE) evaluation *If yes, when?*	☐ Y, in the past	☐ Y, current	☐ N
Has/does your child have an Individualized Education Plan (IEP)? If yes, date?	☐ Y, in the past	☐ Y, current	☐ N
504 Plan *If yes, date?*	☐ Y, in the past	☐ Y, current	☐ N
Attends a special needs daycare/preschool	☐ Y, in the past	☐ Y, current	☐ N
Receiving ☐speech ☐occupational ☐physical therapy	☐ Y, in the past	☐ Y, current	☐ N
Participates in Summer School or Extended School Year (ESY) services	☐ Y, in the past	☐ Y, current	☐ N
Psychological testing? *If yes, date?*	☐ Y, in the past	☐ Y, current	☐ N
Mental health counseling or behavioral therapy? *If yes, date?*	☐ Y, in the past	☐ Y, current	☐ N
School disciplinary actions, including detention, suspension or expulsion? *If yes, specify & date?*	☐ Y, in the past	☐ Y, current	☐ N
Stay in psychiatric hospital	☐ Y, in the past	☐ Y, current	☐ 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.**

<u>This information may be necessary for the Autism Spectrum Center to get authorization from your insurance company.</u>

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

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

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

Developmental Problems:
- ☐ Speech delay
- ☐ Developmental Delay
- ☐ Behavior problems
- ☐ Autism
- ☐ Attention problems (ADD/ADHD)
- ☐ Learning problems

Mental Health Problems:
- ☐ Anxiety
- ☐ Obsessive Compulsive Disorder
- ☐ Mood Disorder (Depression, Bipolar, Suicide thoughts or attempts)
- ☐ Psychosis or Schizophrenia
- ☐ Child has had a stay in a psychiatric hospital

*If yes, when/where?

Neurological Problems:
- ☐ Epilepsy/seizures
- ☐ Cerebral Palsy
- ☐ Hearing problems
- ☐ Sleep problems
- ☐ Tics or Tourette
- ☐ Vision problems
- ☐ Head injury
- ☐ Motor delays
- ☐ Headaches

Genetic Disorders:
- ☐ Down Syndrome/trisomy 21
- ☐ Other chromosomal abnormalities
- ☐ Metabolic disorder

General Medical Problems:
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Congenital heart problem
- ☐ Overweight/Obesity
- ☐ Growth problems
- ☐ Underweight/Failure to thrive
- ☐ Allergies
- ☐ Skin problems (rashes, eczema)
- ☐ Respiratory (asthma, pneumonia)
- ☐ Diabetes
- ☐ Thyroid
- ☐ Kidney/urinary problems
- ☐ Cancer
- ☐ Gastrointestinal problems (vomiting, feeding problems, abdominal pain, reflux, constipation, diarrhea)

Surgical History:
Has your child ever had any surgeries? If yes, please list below:

Any other specific medical concerns?

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	☐ Y ☐ N ☐ Don't know	
EEG	☐ Y ☐ N ☐ Don't know	
CT scan or MRI of the head	☐ Y ☐ N ☐ Don't know	
Sleep study	☐ Y ☐ N ☐ Don't know	
Hearing test	☐ Y ☐ N ☐ Don't know	
Vision test	☐ Y ☐ N ☐ Don't know	

***Review of Systems**

General/constitutional:
- ☐ Significant behavioral changes
- ☐ Significant weight loss or gain
- ☐ Weakness or fatigue
- ☐ Fever or chills

Allergy:
- ☐ Itchy or watery eyes
- ☐ Itchy or runny nose, sneezing
- ☐ Hives
- ☐ Needed to use Epi-Pen

Gastrointestinal:
- ☐ Changes in appetite
- ☐ Abdominal pain or discomfort
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating, indigestion
- ☐ Nausea, vomiting
- ☐ Change in bowel habits (number/consistency)
- ☐ Blood in stool
- ☐ Jaundice (yellow skin or eyes), itching

Neurological:
- ☐ Headaches
- ☐ Dizziness, vertigo
- ☐ Weakness
- ☐ Seizures, convulsions
- ☐ Sleep problems
- ☐ Fainting, blackouts
- ☐ Numbness, tingling
- ☐ Head injuries, concussions
- ☐ Trouble walking
- ☐ Tremor, unusual motor movement (tics)
- ☐ Problems with coordination
- ☐ Problems with concentration, memory

*Review of Systems (continued)

Heart: ☐ Chest pain or pressure ☐ Heart racing, skipped beats ☐ Ankle swelling, cold/blue hands, feet ☐ Fainting, fatigue with exercise	**Lungs:** ☐ Cough ☐ Shortness of breath, wheezing ☐ Recent chest X-ray
Eyes, Ears, Nose, Throat: ☐ Sore throats ☐ Ear infections ☐ Sinus infections ☐ Loud snoring, irregular breathing during sleep ☐ Problems with eyes/vision ☐ Problems with ears/hearing	**Bones, joints, and muscles:** ☐ Joint pain, stiffness, swelling ☐ Fingers painful/blue in cold ☐ Dry mouth, red eyes ☐ Back, neck pain ☐ Muscle problems ☐ Fractures, broken bones ☐ Sprains
Endocrine: ☐ Sweating ☐ Fatigue ☐ Hand trembling ☐ Neck swelling ☐ Skin, hair, voice changes ☐ Thirst ☐ Growth difficulties	**Genitourinary:** ☐ Nighttime bedwetting ☐ Daytime urine accidents ☐ Pain with urination ☐ Frequent urination ☐ Blood in urine ☐ Genital rashes or lumps ☐ Heavy or painful menses (periods)
Skin: ☐ Rashes ☐ Changes in mole or spot ☐ Needed stitches	**Hematologic:** ☐ Bruise easily, difficulty stopping bleeding ☐ 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	☐ Y ☐ N	
Use tobacco	☐ Y ☐ N	If yes: how much?
Drink alcohol	☐ Y ☐ N	If yes: how much?
Take drugs or medications	☐ Y ☐ 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?	☐ Y ☐ N or numbers of weeks gestation at birth:
What was the delivery method? *If cesarean, please describe why:*	☐ vaginal ☐ cesarean (C-section)
Were there any prenatal or neonatal complications? *If yes, please describe:*	☐ Y ☐ N
Was a NICU or extended hospital stay required? *If yes, please describe:*	☐ Y ☐ N

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		☐	☐	☐	☐
Crawled		☐	☐	☐	☐
Stood without support		☐	☐	☐	☐
Walked without assistance		☐	☐	☐	☐
Spoke first words		☐	☐	☐	☐
Said phrases		☐	☐	☐	☐
Said sentences		☐	☐	☐	☐
Bowel trained		☐	☐	☐	☐
Bladder trained, day		☐	☐	☐	☐
Bladder trained, night		☐	☐	☐	☐

****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 Autism Spectrum 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

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A. Child's Behavioral and Emotional Functioning

Check the column that best describes this child's behavior OVER THE PAST 6 MONTHS

	Never or rarely	Occasionally	Often	Very Often
1. Fails to give close attention to detail or makes careless mistakes in schoolwork	☐	☐	☐	☐
2. Has difficulty sustaining attention in tasks or activities	☐	☐	☐	☐
3. Does not listen when spoken to directly	☐	☐	☐	☐
4. Does not follow through when given directions	☐	☐	☐	☐
5. Has difficulties organizing tasks and activities	☐	☐	☐	☐
6. Avoids, dislikes, or does not want to start tasks	☐	☐	☐	☐
7. Loses things necessary for tasks or activities (school assignments, books, pencils, etc.)	☐	☐	☐	☐
8. Is easily distracted by noises or other things	☐	☐	☐	☐
9. Is forgetful in daily activities	☐	☐	☐	☐
OFFICE USE ONLY (I)	(1-9)____/9	☐ **≥6/9**		SUBTOTAL:_____
10. Fidgets with hands or feet or squirms in seat	☐	☐	☐	☐
11. Leaves seat when he/she is supposed to stay in seat	☐	☐	☐	☐
12. Runs about or climbs too much when he/she is supposed to stay seated	☐	☐	☐	☐
13. Has difficulty playing or starting quiet games	☐	☐	☐	☐
14. Is "on the go" or acts as if "driven by a motor"	☐	☐	☐	☐
15. Talks too much	☐	☐	☐	☐
16. Blurts out answers before questions have been completed	☐	☐	☐	☐
17. Has difficulty waiting his/her turn	☐	☐	☐	☐
18. Interrupts or bothers others when they are talking or playing games	☐	☐	☐	☐
OFFICE USE ONLY (HI)	(1-9)____/9	☐ **≥6/9**		SUBTOTAL:_____
19. Argues with adults	☐	☐	☐	☐
20. Loses temper	☐	☐	☐	☐
21. Actively disobeys or refuses to follow adult's requests or rules	☐	☐	☐	☐
22. Bothers people on purpose	☐	☐	☐	☐
23. Blames others for his or her mistakes or misbehaviors	☐	☐	☐	☐
24. Is touchy or easily annoyed by others	☐	☐	☐	☐
25. Is angry or bitter	☐	☐	☐	☐
26. Is hateful and wants to get even	☐	☐	☐	☐
OFFICE USE ONLY (ODD):	(19-26)____/8			☐ **≥4/8**

Check the column that best describes this child's behavior OVER THE PAST 6 MONTHS

	Never or rarely	Occasionally	Often	Very Often
27. Bullies, threatens, or scares others	☐	☐	☐	☐
28. Starts physical fights	☐	☐	☐	☐
29. Lies to get out of trouble or to avoid jobs (i.e., "cons" others)	☐	☐	☐	☐
30. Skips school without permission	☐	☐	☐	☐
31. Is physically unkind to people	☐	☐	☐	☐
32. Has stolen things that have value	☐	☐	☐	☐
33. Destroys others' property on purpose	☐	☐	☐	☐
34. Is physically mean to animals	☐	☐	☐	☐
35. Has set fires on purpose to cause damage	☐	☐	☐	☐
36. Has broken into someone else's home, business, or car	☐	☐	☐	☐
37. Has stayed out all night without permission or run away from home overnight	☐	☐	☐	☐
38. Has used a weapon that can cause serious physical harm (e.g., bat, broken bottle, brick)	☐	☐	☐	☐
OFFICE USE ONLY (CD):		(27-38)____/12		☐ ≥3/12
39. Is fearful, anxious, or worried	☐	☐	☐	☐
40. Is afraid to try new things for fear of making mistakes	☐	☐	☐	☐
41. Feels useless or inferior	☐	☐	☐	☐
42. Blames self for problems, feels at fault	☐	☐	☐	☐
43. Feels lonely, unwanted, or unloved; complains that "no one loves me"	☐	☐	☐	☐
44. Is sad or unhappy	☐	☐	☐	☐
45. Feels different and easily embarrassed	☐	☐	☐	☐
46. Is overly concerned about health/body	☐	☐	☐	☐
OFFICE USE ONLY (Anx/Dep):		(39-46)____/8		☐ ≥3/8
47. Has problems getting along with parent(s)	☐	☐	☐	☐
48. Has problems getting along with others his/her own age	☐	☐	☐	☐
49. Has problems getting along with his/her own siblings	☐	☐	☐	☐
50. Has problems in group activities such as games or team play	☐	☐	☐	☐
OFFICE USE ONLY (Anx/Dep):		(39-46)____/8		☐ ≥3/8
51. Decreased interest or pleasure in all, or almost all, activities of the day	☐	☐	☐	☐
52. Has said things like "I wish I were dead" or has tried to hurt self	☐	☐	☐	☐
53. Recurrent excessive distress when separated from home or caretakers	☐	☐	☐	☐
54. Has distinct periods where mood is unusually irritable or unusually good, cheerful mood (different from normal mood)	☐	☐	☐	☐
55. Has prolonged temper tantrums (greater than 20-30 minutes)	☐	☐	☐	☐

Check the column that best describes this child's behavior OVER THE PAST 6 MONTHS	Never or rarely	Occasionally	Often	Very Often
56. Has compulsions (e.g., child seems driven to wash hands, count, erase until holes appear)	☐	☐	☐	☐
57. Has obsessions (e.g., persistent or repetitive distressing thoughts, germs, doors left unlocked)	☐	☐	☐	☐
58. Has recurrent recollections or dreams of a traumatic event	☐	☐	☐	☐
59. Seems to avoid or have phobias of specific people, animals, things or situations	☐	☐	☐	☐
60. Seem unaware of others' existence, is uninterested in interacting with others	☐	☐	☐	☐
61. Has odd, eccentric, or unusual preoccupations (e.g., clothing items, toys, neatness)	☐	☐	☐	☐
62. Appears uninterested in activities children his/her own age usually like or participate in	☐	☐	☐	☐
63. Has experimented with or abused drugs or alcohol	☐	☐	☐	☐
OFFICE USE ONLY (MH):	(51-64)____/14			☐ ≥0/14

B. Child's Current School Performance

Please check the column that best describes your child's current performance at school, or check "not applicable"

	Not applicable	Excellent	Above average	Average	Somewhat of a problem	Problematic
1. Overall school performance	☐	☐	☐	☐	☐	☐
2. Completing classroom assignments	☐	☐	☐	☐	☐	☐
3. Completing homework	☐	☐	☐	☐	☐	☐
4. Getting homework to and from school	☐	☐	☐	☐	☐	☐
5. Organizational skills	☐	☐	☐	☐	☐	☐
6. Reading	☐	☐	☐	☐	☐	☐
7. Spelling	☐	☐	☐	☐	☐	☐
8. Mathematics	☐	☐	☐	☐	☐	☐
9. Science	☐	☐	☐	☐	☐	☐
10. Written expression	☐	☐	☐	☐	☐	☐
11. Handwriting	☐	☐	☐	☐	☐	☐

C. Child's Overall Functioning

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 your experience.
Please circle only one number.

☐	**Excellent** functioning/No impairment in settings
☐	**Good** functioning /Rarely shows impairment in settings
☐	**Mild** difficulty in functioning/Sometimes shows impairment in settings
☐	**Moderate** difficulty in functioning/Usually shows impairment in settings
☐	**Severe** difficulties in functioning/Most of the time shows impairment in settings
☐	**Needs considerable supervision** in **all** settings to prevent from hurting self or others
☐	**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

Boston Children's Hospital | Autism Spectrum Center
Until every child is well™

K-12 School Questionnaire

Child's Name: *Last _____ *First _____

*Date of Birth: _____ *Gender: ☐**M** ☐**F** ☐**Other**

Child's classroom/age level: _____

Please have school or daycare personnel fill out and return.

Mail: Boston Children's Hospital, Autism Spectrum Center BCH3433, 300 Longwood Ave., Boston, MA 02115
Email: AutismCenter@childrens.harvard.edu Fax: 617-730-4823

School/daycare: _____

School/daycare 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 most improvement?

Please describe this child's strengths.

Please describe any other concerns you have about this child.

Has this child ever been evaluated for learning or academic problems? If yes, when? _____

Please send copies of previous testing results and copy of the current Individual Educational Plan (IEP).

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

If yes, what language? _____

A. ACADEMIC PERFORMANCE:

Current school performance: ***Please check the appropriate column below***

	Excellent	Above average	Average	Somewhat of a problem	Problematic
1. Reading decoding	☐	☐	☐	☐	☐
2. Reading comprehension	☐	☐	☐	☐	☐
3. Reading rate and fluency	☐	☐	☐	☐	☐
4. Spelling accuracy	☐	☐	☐	☐	☐
5. Mathematics concepts	☐	☐	☐	☐	☐
6. Mathematics computation	☐	☐	☐	☐	☐
7. Handwriting	☐	☐	☐	☐	☐
8. Writing rate	☐	☐	☐	☐	☐
9. Punctuation/grammar	☐	☐	☐	☐	☐
10. Ability to express thoughts through writing	☐	☐	☐	☐	☐
11. Gross motor skills	☐	☐	☐	☐	☐
12. Fine motor skills (using pencil & scissors)	☐	☐	☐	☐	☐
13. Overall school performance	☐	☐	☐	☐	☐

Current classroom behavior: ***Please check the appropriate column below***

	Excellent	Above average	Average	Somewhat of a problem	Problematic
1. Understanding verbal instructions	☐	☐	☐	☐	☐
2. Completing classroom assignments	☐	☐	☐	☐	☐
3. Organizational skills	☐	☐	☐	☐	☐
4. Getting homework to and from school	☐	☐	☐	☐	☐
5. Completing homework	☐	☐	☐	☐	☐
6. Relationship with peers	☐	☐	☐	☐	☐
7. Following directions	☐	☐	☐	☐	☐
8. Disrupting class	☐	☐	☐	☐	☐
9. Verbally participating in class	☐	☐	☐	☐	☐

LEARNING PROBLEMS. Check the column that best describes the child's learning problems (i.e., above and beyond what would be expected for his or her developmental age) over the past 6 months.

	Never or rarely	Occasionally	Often	Very Often
1. Has trouble learning new material in an appropriate time from for age and skills	☐	☐	☐	☐
2. Has little desire to master new skills	☐	☐	☐	☐
3. Unable to tell time, days of the week, months of the year	☐	☐	☐	☐
4. Can't repeat information	☐	☐	☐	☐
5. Knows material one day; doesn't know it the next	☐	☐	☐	☐
6. Has trouble holding several different things in mind while working	☐	☐	☐	☐
7. Has trouble following multi-step directions	☐	☐	☐	☐
8. Has difficulty copying written material from blackboard	☐	☐	☐	☐
OFFICE USE ONLY (Gen):	(1-8)____/8			☐ **≥4/8**
9. Difficulty orienting self (e.g., gets lost, can't find way, or gets turned around easily)	☐	☐	☐	☐
10. Has poor spatial judgment and often bumps into things	☐	☐	☐	☐
11. Confuses directionality (up/down, left/right, over/under)	☐	☐	☐	☐
12. Has poor spatial organization on paper (difficult staying in lines, maintaining space between words, staying within page margins)	☐	☐	☐	☐
13. Mixes up capital and lower case letters when writing	☐	☐	☐	☐
14. Reverses letters and numbers	☐	☐	☐	☐
OFFICE USE ONLY (VSP):	(9-14)____/9			☐ **≥3/6**
15. Has trouble expressing words or events in correct order	☐	☐	☐	☐
16. Often mispronounces known or familiar words or uses wrong word	☐	☐	☐	☐
17. Has trouble verbally expressing thoughts	☐	☐	☐	☐
18. Says things that have little or no connection to what others are discussing	☐	☐	☐	☐
19. Has difficulty distinguishing long vowel sounds and short vowel sounds	☐	☐	☐	☐
20. Depends on teacher or others for repetition of task instructions	☐	☐	☐	☐
OFFICE USE ONLY (Lang):	(15-20)____/6			☐ **≥3/6**
21. Displays poor word attack skills (can't sound out words)	☐	☐	☐	☐
22. Puts wrong number of letters in words	☐	☐	☐	☐
23. Confuses consonant sounds, e.g.: b-d, d-t, m-n, p-b, f-v, s-z	☐	☐	☐	☐
24. Unable to keep place on page when reading	☐	☐	☐	☐
OFFICE USE ONLY (R/W):	(21-24)____/4			☐ **≥2/4**

CLASSROOM SETTING: Please check all that apply, and provide details

Type of Setting	Number of Students	Number of Instructors	Aide Present for Child?		
☐ Mainstream			☐ 1:1	☐ Shared	☐ None
☐ Integrated			☐ 1:1	☐ Shared	☐ None
☐ Substantially separate			☐ 1:1	☐ Shared	☐ None

GENERAL EDUCATION SETTING: Please list any specific curricula or instructional methodologies used in the child's general education setting, if applicable

Academic Area	Methodology or curriculum
Reading/reading-related materials	
Mathematics	
Writing/written expression	

SPECIAL EDUCATION AND RELATED SERVICES FOR CHILD: Please check all that apply and describe specific curriculum or instructional methodology, if applicable

☐ Check here if you are not familiar with the child's IEP services

Type of service	Consultation	Direct service within general education classroom	Direct service in other settings	Specific curriculum or instructional methodology, if applicable (e.g., reading –Wilson)
☐ Occupational therapy	☐	☐	☐	
☐ Physical therapy	☐	☐	☐	
☐ Speech/language therapy	☐	☐	☐	
☐ Reading	☐	☐	☐	
☐ Mathematics	☐	☐	☐	
☐ Written language	☐	☐	☐	
☐ Behavior	☐	☐	☐	
☐ Social skills	☐	☐	☐	
☐ Individual counseling	☐	☐	☐	
☐ Home-based services	☐	☐	☐	
☐ Other (specify):	☐	☐	☐	
☐ Other (specify):	☐	☐	☐	
☐ Other (specify):	☐	☐	☐	
☐ Other (specify):	☐	☐	☐	

B. CHILD'S ATTENTION, ACTIVITY, AND BEHAVIOR

Check the column that best describes this child's behavior OVER THE PAST 6 MONTHS

	Never or rarely	Occasionally	Often	Very Often
1. Fails to give close attention to detail or makes careless mistakes in schoolwork	☐	☐	☐	☐
2. Has difficulty sustaining attention in 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 (e.g., school assignments, books, pencils, etc.)	☐	☐	☐	☐
8. Is easily distracted by extraneous stimuli	☐	☐	☐	☐
9. Is forgetful in daily activities	☐	☐	☐	☐
OFFICE USE ONLY (I)	(1-9)____/9	□ **≥6/9**		SUBTOTAL:_____
10. Fidgets with hands or feet or squirms in seat	☐	☐	☐	☐
11. Leaves seat when he/she is supposed to stay in seat	☐	☐	☐	☐
12. Runs about or climbs too much when he/she is supposed to stay seated	☐	☐	☐	☐
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 his/her turn	☐	☐	☐	☐
18. Interrupts or intrudes on others (e.g. when they are talking or playing games	☐	☐	☐	☐
OFFICE USE ONLY (HI)	(1-9)____/9	□ **≥6/9**		SUBTOTAL:_____

Check the column that best describes this child's behavior OVER THE PAST 6 MONTHS

	Never or rarely	Occasionally	Often	Very Often
19. Loses temper	☐	☐	☐	☐
20. Actively defies or refuses to comply with adult's requests 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 for favors or to avoid obligations (i.e., "cons" others)	☐	☐	☐	☐
26. Is physically cruel to people	☐	☐	☐	☐
27. Has stolen items of nontrivial value	☐	☐	☐	☐
28. Deliberately destroys others' property	☐	☐	☐	☐
OFFICE USE ONLY (ODD/CD):	(19-28)____/10			☐ **≥3/10**
29. Appears fearful, anxious, or worried	☐	☐	☐	☐
30. Appears self-conscious or easily embarrassed	☐	☐	☐	☐
31. Appears 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. Appears sad, unhappy, or depressed	☐	☐	☐	☐
OFFICE USE ONLY (Anx/Dep):	(29-35)____/7			☐ **≥3/7**
36. Skips school without permission	☐	☐	☐	☐
37. Has set fires on purpose to cause damage	☐	☐	☐	☐
38. Destroys others' property on purpose	☐	☐	☐	☐
39. Has broken into someone else's home, business, or car	☐	☐	☐	☐
40. Has said things like "I wish I were dead" or has tried to hurt self	☐	☐	☐	☐
41. Has distinct periods where mood is unusually irritable or unusually good, cheerful, or high which is clearly excessive or different from normal mood	☐	☐	☐	☐
42. Seems to have compulsions (repetitive behaviors that this child seems driven to carry out, such as repeated hand washing, counting, or erasing until holes appear)	☐	☐	☐	☐
43. Has prolonged temper tantrums (greater than 20-30 minutes)	☐	☐	☐	☐
44. Seems unaware of others' existence, is uninterested in interacting with others	☐	☐	☐	☐
45. Has odd, eccentric, or unusual preoccupations (e.g., clothing items, toys, neatness)	☐	☐	☐	☐
46. Appears uninterested in activities children his/her own age usually like or participate in	☐	☐	☐	☐
OFFICE USE ONLY (MH):	(36-46)____/11			☐ **≥1/11**

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.

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

Please describe this child's personality – moods, behavior, emotional functioning, etc.

Please describe this child's relationship with peers.

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

*Teacher Signature *Print Name *Date