

Intake Information

Date _____

Child's Name *first* _____ *last* _____

Parent/Guardian's 1. *first* _____ *last* _____

Full Name(s) 2. *first* _____ *last* _____

Child's Age _____ Date of birth _____

Primary Language Spoken at Home _____

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

Since the Developmental Medicine Center has a waiting list, some problems need more urgent attention. If your child has any of the following problems please also contact your pediatrician. Please notate if you have any urgent medical concerns including concerns about any of the following:

Seizures Yes No

Loss of skills Yes No

Developmental regression Yes No

Loss of hearing Yes No

Loss of vision Yes No

Other (please describe) _____

Do you have any other urgent concerns including concerns about any of the following:

Safety of any family members including this child Yes No _____

(explain)

History of suicidal/thinking or attempt of child or family members Yes No _____

(explain)

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

1. _____

2. _____

3. _____

Has your child been seen in the Developmental Medicine Center before? Yes No

If yes, when? _____

Was this for a team visit or an appointment with a single provider? _____

Preferred contact information

Your full name	Relationship to child
Home address <i>Street</i>	Email address
<i>City/town</i>	
<i>State</i> <i>Zip</i>	
Telephone (h) (w) (cell)	

Other contact information

Full name	Relationship to child
Home address <i>Street</i>	Email address
<i>City/town</i>	
<i>State</i> <i>Zip</i>	
Telephone (h) (w) (cell)	

Legal guardian (if different from above)

Full name	Relationship to child
Home address <i>Street</i>	Email address
<i>City/town</i>	
<i>State</i> <i>Zip</i>	
Telephone (h) (w) (cell)	

Child lives with

Both parents Mother Father Other (explain) _____

Check if applicable for child

Child adopted Child in Foster Care Guardianship Other (explain) _____

If your child is adopted, in foster care, or guardianship, at what age did child come into your home? _____

Language(s) spoken in the home:	Family Religion
Do you or your child require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	

In order to properly assign your child to the appropriate provider(s) please submit copies of any early intervention, IEP (previously known as CORE), academic, psychological, or school testing from the past five (5) years. This information may be necessary for insurance referrals. Please list documents and date of testing of all materials sent in:

Please list any current or prior medical, developmental, or psychological diagnoses:

Please list any prior genetic, EEG testing:

List any medications, and dose, child takes at present:

Primary Care Provider (i.e. pediatrician, nurse practitioner): _____

Does your child see other specialists (i.e. neurologist): _____

Please list any mental health providers and/or programs that are involved with your child (i.e. counselors, psychologists, DSS, DMR, DMH, residential program).

Are there any other concerns in the family that would be helpful for us to know about? Are there any other specific sources of stress, such as a family move, trauma, extreme parental pressure or loss that would be helpful for us to know about?

Are you looking for additional support for yourself in handling your child's needs and behavior?

DEVELOPMENTAL HISTORY

If you can recall, record the age at which your child reached the following developmental milestones.

If you cannot recall, check the appropriate box at right on the chart below.

Developmental Skill	Age	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					

Is there anything else we should know about your child or family?

Is there anything you would like us to know about the religious, spiritual, cultural beliefs, traditions or practices of your family or extended family?

I/we are interested in hearing and learning more about research opportunities in the Division of Developmental Medicine Yes No

Please attach a recent photograph of your child, if available, in the space below.

Attach Photograph Here

Thank you for completing this form *DMC Staff*

Insurance Information

Please fill out the following 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.

Prior authorizations are often required by most insurance companies for neuropsychological/psychological testing and/or mental health visits. ****Please call your insurance carrier prior to the appointment to inquire about coverage. Payment for the visit is your responsibility**** Prior authorization is not a guarantee of payment coverage. If you have any questions, please call the insurance coordinator at 617-355-0965.

Parent Name: _____

Primary Insurance Carrier: _____

Group name & number (if applicable): _____

Patient name: *First* _____ *Last* _____

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): _____

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): _____