the Developmental Medicine Center
at Children's Hospital Boston

Children's Hospital Boston
300 Longwood Avenue
Boston, Massachusetts 02115

Intake Information

Date ______________________________

Child's Name *first* ______________________ *last* ______________________

Parent/Guardian's Full Name(s) 1. *first* ______________________ *last* ______________________

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 suiciality, 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 *Street*	Email address
City/town	
State *Zip*	

Telephone (h) (w) (cell)

Other contact information

Full name	Relationship to child
Home address *Street*	Email address
City/town	
State *Zip*	

Telephone (h) (w) (cell)

Legal guardian (if different from above)

Full name	Relationship to child
Home address *Street*	Email address
City/town	
State *Zip*	

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? ☐ Yes ☐ 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.

			Only if exact age cannot be recalled		
Developmental Skill	**Age**	**Not yet**	**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*

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fax (617) 730-0252

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): ______________________________

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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): ______________________________

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