the Developmental Medicine Center
at Children's Hospital Boston

Children's Hospital Boston
300 Longwood Avenue
Boston, Massachusetts 02115
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Child and Parent Program - Parent Form

Date

Child's Name | Date of Birth
First | *Last*

Parent/Guardian Full Name(s) | Relationship to Child
1. *First* | *Last*
2. *First* | *Last*

Primary Language Spoken at Home

Telephone (Home) | (Work)

Email address | (Cell)

Home Address *Street* | Family Religion
City/town
State | *Zip*

Nursery School or Childcare Program | Teacher

Address

Early Intervention Program | Case Manager

Address

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

Has your child ever been given a diagnosis for concerns about delayed development including learning, behavior, or emotional problems?

Diagnosis ______ Approx. Date of Diagnosis ______

Diagnosed by ______ Who works at ______

**It is especially important that you share this information with us if you are concerned about an autism spectrum disorder including Autistic Disorder, PDD-NOS, or Asperger's Disorder. This information is critical in directing your child's referral for the earliest possible appointment.*

Please list the question(s) you would like answered once the evaluation is completed:

1. ______
2. ______
3. ______
4. ______

Whose idea was it that your child have an evaluation? ______

BIRTH HISTORY

Which of the mother's pregnancies was this ? (1st, 2nd, etc.)? ______________________

Has the mother had miscarriages? ☐ Yes ☐ No

Previous premature baby(ies)? ______________________

During pregnancy *(please check Yes or No if the following occurred. If Yes, please describe briefly)*

☐ Yes ☐ No Illness/infection/accident Describe: ______________________

☐ Yes ☐ No Medication taken Describe: ______________________

☐ Yes ☐ No Smoking If yes, how much: ______________________

☐ Yes ☐ No Alcohol intake If yes, how much: ______________________

☐ Yes ☐ No Drug intake If yes, how much: ______________________

Length of pregnancy in weeks (most babies are born between 38-42 weeks): ______________________

Labor

☐ Yes ☐ No Induced

☐ Yes ☐ No Lasted over 12 hours

Delivery

☐ Yes ☐ No Caesarean section If yes, how much: ______________________

☐ Yes ☐ No Anesthesia If yes, what type: ☐ Spinal ☐ Epidural ☐ General (asleep)

Newborn

Birth weight: ______________ Cried right away ☐ Yes ☐ No

Apgar scores, if known: ______________________

☐ Yes ☐ No Complications If yes, describe: ______________________

____

☐ Yes ☐ No Breast fed If yes, how long? ______________________

Went home after ________ days in the hospital

Infancy

☐ Yes ☐ No Enjoyed cuddling

☐ Yes ☐ No Fussy, irritable

☐ Yes ☐ No More active than others

Other: ______________________

Describe your child's personality - moods, relationships, behavior:

Describe your child's strengths.

Please add any additional information which you feel may help us better understand your child.

FAMILY HISTORY

please answer in the appropriate column	MOTHER		FATHER		
Age					
Occupation					
Highest Grade Completed					
Learning problems					
Speech problems					
Behavior problems					
Medical problems					
Emotional problems					
Drug or alcohol abuse					
Deceased					
Child lives with					
Parents are (circle one)	Married	Living together	Separated	Divorced	Other

please answer in the appropriate column	Relationship to child	Mother's side	Father's side
Behavior problems, hyperactivity			
Drug or alcohol abuse			
Emotional/mental health problems (please sepcify)			
Learning problems			
Speech problems			
Ambidexterity or left hand preference			
Migraine headaches			
Mental retardation			
Thyroid disease			
Seizures or epilepsy			
Lead poisoning			
Other neurological problems			
Tourette's syndrome			
Fragile X			
Other chromosomal problems			

SIBLINGS

Name	Age	Medical, social, academic, speech problems

CHILDCARE EXPERIENCE

For each setting attended by your child, estimate the number of hours or days in the appropriate column.

	Ages 0-6 mos	Ages 7-12 mos	Ages 1-2 yrs	Ages 2-4 yrs
Nursery or Preschool				
Childcare				
Other:				

DEVELOPMENTAL HISTORY

If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall the age, check the appropriate box at right on the chart below.

	Age	Early	At normal time	Late
Smiled				
Sat without support				
Crawled				
Stood without support				
Walked without assistance				
Threw ball				
Spoke first words				
Said phrases				
Said sentences				
Showed clear hand preference				
Bowel trained				
Bladder trained, day				
Bladder trained, night				
Rode tricycle				
Named colors				

CURRENT PERFORMANCE

How well does your child function in the following ares compared with his or her age peers?

	About like peers	Better than peers	Behind peers
Balancing			
Walking			
Running			
Throwing			
Understanding directions			
Dressing self			
Remembering			
Playing alone			
Playing with others			

ACTIVITY, ATTENTION, BEHAVIOR

please check the appropriate column	Not True	Sometimes True	Very/Often True
1. Fails to finish things he/she starts			
2. Can't concentrate, can't pay attention for long			
3. Can't sit still, restless, or hyperactive			
4. Fidgets			
5. Daydreams or gets lost in his/her thoughts			
6. Impulsive or acts without thinking			
7. Has difficulty following directions			
8. Is inattentive, is easily distracted			
9. Disturbs other children			
10. Demands must be met immediately			
11. Is easily frustrated			
12. Cries often and easily			
13. Mood changes quickly and drastically			
14. Has temper outbursts: is explosive			
15. Head bangs			
16. Rocks in bed			
17. Unsafe behaviors			
18. Is difficult to comfort			
19. Is stiff/rigid			
20. Exhibits looseness/floppiness			
21. Is shy with strangers			
22. Is shy with peers			
23. Shows extreme reaction to noise			
24. Has difficulty keeping to schedule or schedule changes			
25. Has difficulty getting satisfied			
26. Fails to be affectionate towards parents			
27. Tics (excessive movements/odd sounds)			

MEDICAL HISTORY

please check the appropriate column	No	Yes	Details
Hearing test			At what age?
Ear infections			Starting at what age?
Were tubes ever put in place?			
Were antibiotics ever given to prevent ear infections?			
Vision Problems			
Headaches			
Seizures			
Meningitis			
Asthma			
Pneumonia			
Heart problems			
Anemia			
Elevated lead level			
Slow/fast weight gain			
Stomachaches			
Feeding difficulties			
Sleeping difficulties			
Kidney/urinary problems			
Constipation/diarrhea			
Accidents (broken bones, sutures)			
Allergies			
Hospitalization			

List any medications, and doses, your child currently uses:

Other health problems:

FUNCTIONAL HISTORY

please check the appropriate column	No	Yes	Details
Feeding Difficulties			At what age?
Sleeping Difficulties			Starting at what age?
Colic			
Stomachaches			

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

Attach photo here

Thank you for your help! ***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****. If you have any questions, please call the insurance coordinator at 617-355-0965. **Prior authorization is not a guarantee of payment coverage.**

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): ______________________________

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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): ______________________________

____

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