Boston Children's Hospital

Deaf and Hard of Hearing Program
9 Hope Avenue
Waltham, MA 02453
FAX 781-216-3688
www.childrenshospital.org

A teaching affiliate of Harvard Medical School

Deaf and Hard of Hearing Program
Boston Children's Hospital – Pediatric Questionnaire

The information on the following pages will help to ensure that your child is scheduled appropriately. Please fill out this questionnaire completely, **including all school and insurance information**. You will be contacted once we have reviewed the information to follow-up on scheduling arrangements.

Today's Date_____

Child's Legal Name_____ Date of Birth_____
Boy _____ *Girl* _____

Parent/ Guardian Name_____

Address_____

City, State, & Zip Code_____

Name of person completing questionnaire_____

Phone number: (h)_____(w)_____

Email: _____

Who referred you to DHHP? _____

Has the child ever been seen at Children's Hospital? _____

What degree of hearing loss does this child have? _____

How might DHHP help you (questions, problems, concerns)? REQUIRED

_____

_____

_____

If psychological testing is requested, indicate how results will facilitate treatment goals and/or provide information beyond that currently available?

_____

_____

_____

_____

Financial/Insurance Information:
PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD (FRONT AND BACK)
Who will be responsible for this child's appointment(s)? Please check **one** of the following:

❍ *Health Insurance*

Health Insurance Provider: _____

Policy Holder's Name: _____

Policy Number(s) for Child: _____ Group Number: _____

Primary Care Physician's Name: _____

Address_____

City, State, Zip Code_____

Phone Number_____

If you are requesting a cognitive, psychoeducational and/or social-emotional evaluation, or a consult with a psychologist or psychiatrist, we will need the following information to process a mental health referral authorization:
(Please note that for evaluations/consultations conducted by a psychologist you will need to check on benefits for behavioral health with your insurance and this type of visit may be subject to deductibles/co-insurance. Also – note that Boston Children's Hospital is not considered to be in-network with some companies - please confirm your eligibility for evaluation with BCH)

Mental Health Insurance Provider: _____

Mental Health Provider Phone Number: _____

***Please note that some plans require an initial diagnostic session before a referral for psychological testing can be approved. Also – most plans will not pay for testing done for educational purposes. Please confirm coverage with both your insurance and school district.**

❍ *School System – Please include a letter from the school system stating their intention to be financially responsible for this appointment.* **It is also helpful if a specific list of questions/concerns is included as well.**

School System Name: _____

Address_____

City, State, Zip Code_____

Contact Person_____

Phone_____ Email address_____

PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible care and services to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. In order to reduce confusion and misunderstanding between our patients and our practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our practice manager.

Your insurance policy is a contract between you and your insurance company, Boston Children's Hospital is not involved. If for any reason (including referral disputes) your insurance company does not pay your bill, you shall ultimately be responsible.

All referrals/authorizations (when required by your insurance contract) must be in place prior to the patient's appointment. A patient, whose family does not have their insurance referral and/or wishes to be seen outside their plan, may pay for their visit at time of service.

_____

Signature of Parent or Guardian

_____

Name of Parent or Guardian (please print)

_____

Name of Child

Birth History

Did you or your doctor(s) note problems with any of the following? If so, please describe:

Pregnancy? _____

Labor? _____

Delivery? _____

The child who is being evaluated was the _____ of the mother's pregnancies (first, second, etc.)

Was this child full-term? _____

Mother's age at the time of delivery: _____

Father's age at the time of delivery: _____

Medical History

Has anyone in the family experienced the following? If so, please describe:

Seizures/Epilepsy_____

Neurological Disease or Disorder: _____

Mental health Problems (depression, anxiety, etc.)_____

Intellectual Disability _____

Are any other family members Deaf or Hard of Hearing? If so, please list: _____

What was the reported condition of this child at the time of birth? _____

("Normal," "Poor," "Good," etc.)

Has the child experienced any of the following? If so, please describe:

Jaundice_____

"Rh" Problems_____

Chemical Abnormalities_____

Seizures/Convulsions_____ (at what age?)_____

(Were seizures/convulsions associated with a high fever?)_____

Serious Illnesses_____ (when?)_____

Hospitalizations_____

(why?)_____

(when?)_____ (for how long?)_____

Surgeries_____
Why? _____
When? _____

What were the circumstances of any serious physical injury that the child has experienced?
_____
_____

Was the child:

- Conscious? _____
- Dizzy? _____
- Experiencing a headache? _____

Does the child complain of abdominal pains/ vomiting? _____ how often? _____
When does this usually occur? (bedtime, after play, etc.)_____

Does the child complain of headaches? _____ how often? _____
When does this usually occur? (bedtime, after play, etc.)_____

Does the child have vision problems? If so, please describe: _____

Does the child have any medication allergies? _____

Other allergies? _____

Is this child currently taking any medications? _____ If so, please list:

_____

Developmental History

At what age did your child achieve the following milestones? (If applicable)

Gross motor skills (walking, hopping, riding a bicycle, etc.)_____

Fine motor skills (fastening buttons, using zippers, tying shoelaces, drawing, etc.)_____

Early school-related skills (naming colors, reciting the alphabet, recognizing coins, etc.)_____

Sitting still for television or storytelling_____

Playing/socializing with other children_____

Building with blocks, playing with puzzles, drawing pictures_____

Difficulty separating from parents/ others? _____ If so, at what age? _____

At what age was this child toilet trained for daytime hours? _____
For nighttime hours? _____

Has this child experienced any difficulties in sleeping? If so, please explain: _____

Does the child being evaluated show a clear hand preference? If so, which hand does s/he prefer?
_____

If left-handed, is anyone else in the family left-handed? _____

Does this child play primarily with younger, older, or same-aged children? _____

Does this child have the opportunity to play with children of his or her same age? _____

Has this child ever received psychotherapy and/or counseling? _____

Family History

Are any other family members Deaf or Hard of Hearing? If so, please list_____

_____

With whom does this child live at the present time? (Please include parents, siblings, grandparents, friends, etc.):_____

Name, age, and date of birth(s) of sibling(s):_____
_____

Is the child who is being evaluated: ❍biological ❍adopted ❍a foster child
What language(s) is used at home? _____
Which is the primary language of the home? _____ of this child? _____

Please be aware that DHHP professionals are fluent in Sign Language and/or have access to the services of a Sign Language Interpreter. Would you like a spoken foreign language interpreter available for you during your child's appointment? ❍ No ❍ Yes – what language? _____

Please describe the following:
Mother's occupation: _____
Highest educational level achieved by mother: _____
Father's occupation: _____
Highest educational level achieved by father: _____

School History

Name, address, and grade level of the school/program that the child currently attends:
_____
_____
_____

What schooling did this child have prior to the school/program listed above? _____

Did/does this child attend an Early Intervention and/or Parent/Infant Program? If so, please describe:

_____

Has this child received previous testing under the provisions of a school system, hospital, or clinic?
_____ Where? _____

Please list the dates and types of previous evaluations done outside of Boston Children's Hospital and send report copies to DHHP:

_____

_____

What communication system(s) is used in the school setting? _____

At home? _____

Any other information you feel is important for DHHP clinicians to know before evaluating your child:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this pediatric questionnaire. All information is for Children's Hospital use only and will not be shared with unauthorized persons without your consent.

Parent/ Guardian Signature_____

Date_____

All information should be sent to:

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