Mass General Brigham
Salem Hospital

Neurodevelopmental Clinic

Salem Hospital, 57 Highland Avenue, Salem, MA 01970 (978) 354-2705

Dear parent or guardian;

Thank you for inquiring about an evaluation for your child. At the Neurodevelopmental Clinic we offer neuropsychological, psychological and psycho-educational testing. In addition to diagnostic services, the Neurodevelopmental Clinic also offers a number of related services, including:

- Attendance at school meetings (billed at an hourly rate, including travel time);
- Consultation to parents, schools and other agencies;
- Social skills groups

For children who need evaluations in several clinical areas, such as Speech & Language, Occupational Therapy, Physical Therapy and Pediatric Neurology, evaluations can be coordinated through our Multidiscipline Evaluation Clinic (MDEC).

Because of the extensiveness of these evaluations, they generally take place over the course of two full days. Individuals who are interested in an MDEC evaluation should also complete and return the attached Intake Form.

After your intake is returned and screened, a preliminary meeting between you and one of our psychologists will be scheduled to further clarify your concerns and your child's needs.

The following are the typical steps involved in scheduling an evaluation:

Please complete and return the attached Intake Form (below) as soon as possible. These forms provide us with valuable information necessary to determine the type of services needed. Any additional information which you believe might be relevant, such as other recent evaluations (e.g. a School or CORE evaluation, prior psychological or neuropsychological testing

reports), special education plans (Individual Education Plans, or IEPs), or recent therapy reports, should also be sent. This information is reviewed when it is received. You will be contacted if we have any initial questions. Once you return the Intake Form, you will be placed on our Wait List.

Please inform us if testing is scheduled or being requested elsewhere in the near future (e.g., through school).

A brief initial meeting, typically lasting 45 – 50 minutes, will be scheduled prior to the evaluation. A few notes about this meeting:

A. It allows us to better understand your questions and concerns and to determine how best to serve you.

B. Most insurance companies require prior authorization for psychological or neuropsychological testing. At this time, alternative options for covering these evaluations can be discussed. The hospital accepts most insurances in Massachusetts. Please note that most insurance companies do not pay for testing solely for educational purposes.

C. Children under the age of 18 do not typically need to come to these initial meetings.

D. If there are alternative custody arrangements (e.g., DCF involvement, only one parent having custody, temporary custody etc.) it is critical for our staff to be aware of these arrangements. Please bring documentation of the custody agreement with you on the day of the initial consultation. *Testing cannot be completed with out this documentation.*

E. Insurance companies may cover the cost of this initial meeting. Please check with your own insurance company.

F. We typically have a long wait list and, therefore, an initial meeting will likely not be scheduled immediately after sending in the Intake Form.

Once authorization is obtained, the actual evaluation will be scheduled. The testing appointment is typically scheduled 2 to 4 weeks after the initial meeting.

G. An adult must be present at the hospital for the duration of the evaluation. A parent or guardian should accompany the child to the Clinic. (It is not necessary for both parents to attend). If someone else has to bring your child to the Clinic, please send a signed consent form giving us permission to test your child. This note should be signed by parent or guardian and sent along with your child on the day the appointment is scheduled.

H. Depending on the type of evaluation required, it could take anywhere from a few hours to a full day. Parents should be prepared to take their child to lunch if the evaluation takes more than the morning and should also be prepared to stay for the length of the appointment.

I. Please do not bring your child if he/she has an illness that may be contagious or transmittable (for example, the flu, chicken pox, conjunctivitis, strep throat). Your appointment can be rescheduled when your child is well.

J. If your child normally takes medication, please discuss this with the clinician prior to the day of testing.

Please return completed forms to:
Neurodevelopmental Clinic
Salem Hospital
57 Highland Avenue
Salem MA 01970

Or you may fax to: (978) 740-4960

Questions? Call: (978) 354-2705

Neurodevelopmental Clinic

(978) 354-2705 FAX: (978) 740-4960

History-Intake Form

Patient Name:	Date of Birth: Age: ☐ Adopted ☐ Foster Child		
Address:	City:	State:	Zip Code:
Guardian/Contact:	Please check if this person is: Parent ☐ Foster parent ☐ DCF ☐ Other ☐		
Who has legal custody of this child?			
Email Address:			
Home Phone:	Work Phone:	Cell Phone:	

Payor Information (please check one):

Insurance ☐	If using your Health Insurance, please indicate the following (from insurance card): Insurance Company:_____ Telephone #:_____ Policy #:_____ Policy holder's name:_____ Mental Health Benefits telephone # (see back of insurance card): _____ Secondary insurance (if any): Telephone#:
School ☐	**NOTE**: *If asking school to pay, please include a letter of agreement from school.*
Self-pay ☐	

Who referred you?:

Name:	Connection to Patient:
Agency (if applicable):	Phone #:
Do we have your permission to contact this person if necessary? ☐ Yes ☐ No	

Brief Problem Description:

What is your main question or concern?
What have you been told by doctors, teachers and/or others about the patient's problem?

Has your child been given a diagnosis? ☐ Yes ☐ No	When?	By Whom?	What diagnosis?

In order to guarantee that all patients receive the highest quality of care and to ensure the best services possible, we at NSMC are asking all patients about their race, ethnicity, and language

Race of patient (optional):	Ethnicity of patient (optional):

Family Information:

Name	Relationship to patient	Occupation or Grade:	Living with the patient?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Unmarried			
If separated or divorced, with whom is patient living?			

Family Medical History:

Please identify any of the child's biological relatives (brother, sister, parent, uncle, aunt, cousin, grandparent, etc.) who have had any of the following conditions.		
Condition:	Relationship to patient: (father, sister, aunt, etc.)	Please elaborate:
☐ Attention Problems/ Hyperactivity		
☐ School Difficulties/ Learning Disabilities		
☐ Emotional Problems (e.g., Depression, Anxiety)		
☐ Autism/PDD Asperger's syndrome		
☐ Communication/ Language Problems		
☐ Social Difficulties		
☐ Alcoholism or Substance Abuse		
☐ Intellectual Disability		

☐ Seizure Disorder		
Does the patient remind you of any of the above noted relatives? ☐ Yes ☐ No Please elaborate:		

Pregnancy & Birth History:

Name of birth mother:	Birthplace:
During pregnancy, did mother: Drink alcohol? ☐ Yes Take any drugs? ☐ Yes Smoke cigarettes? ☐ Yes Take any medications? ☐ Yes Was this an In Vitro fertilization? ☐ Yes ☐ No	
Birth was: Normal ☐ Cesarean ☐ Breech ☐ Multiple Births ☐	
Birth weight:	Full term? ☐ Yes ☐ No If premature, how many weeks early?
Were there any complications? ☐ Yes ☐ No If yes, please specify:	

Early Developmental History:

Were there any problems in the first year of life? ☐ Yes ☐ No If yes, please specify:

During the first 12 months, was this child:

Difficult to feed? ☐ Yes ☐ No	Easy to comfort? ☐ Yes ☐ No
Difficult to get to sleep? ☐ Yes ☐ No	Alert? ☐ Yes ☐ No
Difficult to put on a schedule? ☐ Yes ☐ No	Cheerful? ☐ Yes ☐ No
Colicky? ☐ Yes ☐ No	Affectionate? ☐ Yes ☐ No
Overactive/in constant motion? ☐ Yes ☐ No	Sociable? ☐ Yes ☐ No

How old was child when (s)he:	Age	If not sure of age, please estimate if:		
Walked:		Early ☐	Average ☐	Late ☐
Said first words:		Early ☐	Average ☐	Late ☐
Began using sentences:		Early ☐	Average ☐	Late ☐
Toilet trained:		Early ☐	Average ☐	Late ☐

Has s(he) ever had:

Chronic ear infections ☐ Yes ☐ No	Lead poisoning ☐ Yes ☐ No
Seizures ☐ Yes ☐ No	Head injury or concussion ☐ Yes ☐ No
Has s(he) ever had any serious illness or hospitalization? ☐ Yes ☐ No (If yes, please describe:)	

Medical Information:

Name of Pediatrician: Telephone #: Address:
Is this child generally in good health? ☐ Yes ☐ No (If no, please describe:)
Does this child have any allergies? ☐ Yes ☐ No (If yes, to what?)
If child is taking any medications currently, please list: 1. Medication:_____ Reason:_____ 2. Medication: Reason:
If child is seeing any other specialists, please list: 1. Specialist:_____ Reason:_____ 2. Specialist: Reason:

Educational Information:

Name of Current School:	Grade:	Telephone #:
Address:	Name of teacher or contact:	
Has (s)he ever repeated a grade? ☐ Yes ☐ No If yes, which grade:	Is there an IEP? ☐ 504 plan? ☐ Are you appealing it?: ☐ Yes ☐ No	
Has (s)he ever received any special/extra help in school? ☐ Yes ☐ No	Is (s)he *currently* receiving any special/extra help in school?: ☐ Yes ☐ No	

If yes, please check off type of services received:

Reading ☐	Resource Room ☐	In-class help ☐	Separate class ☐	Aide ☐
Occupational Tx ☐	Physical Tx ☐	Speech/Language Tx ☐	Counseling ☐	
Other (specify):				
Has (s)he ever had a developmental, psychological, neuropsychological or educational (CORE)evaluation? ☐ Yes ☐ No If yes, when?: Where?:				
Have you requested or is your child scheduled to be tested through the school in the near future (e.g., CORE evaluation)? ☐ Yes ☐ No If scheduled, when?				

***IMPORTANT: PLEASE SEND COPIES OF MOST RECENT EVALUATIONS, REPORTS AND EDUCATIONAL PLANS (IEPs, 504 Plans) WITH THIS FORM.**

Behavior/Mental Health:

Does your child receive any mental health services (therapy, counseling)? ☐ Yes ☐ No If yes, Agency: _____ Therapist: _____ Phone #: Reason:
Is there any DCF or DYS involvement? No ☐ Yes: Now ☐ In the past ☐

Language and Speech:

What is child's main language(s): What is parents' main language(s): What is child's primary way of communicating? Talking ☐ Signs ☐ Gestures ☐
Does your child have any: Hearing problems? ☐ Yes ☐ No
Has (s) ever had an Audiology evaluation? ☐ Yes ☐ No If yes, when? What were the results?
Does (s)he have any problems understanding what is said to him/her? ☐ Yes ☐ No
Does (s)he have any speech problems/difficulty speaking? ☐ Yes ☐ No
Has (s)he ever had a Speech & Language evaluation? ☐ Yes ☐ No If yes, when? What were the results?
Has (s)he received Speech & Language therapy: Currently? ☐ In the past? ☐ If yes, where?
Do you have any concerns about his/her speech/language that you think requires a Speech/Language evaluation now? ☐ Yes ☐ No Please Elaborate:

Fine Motor Skills:

Does your child have any **fine motor** problems (writing, drawing, etc.)? ☐ Yes ☐ No Specify:
Has (s)he ever had an Occupational Therapy (OT) evaluation? ☐ Yes ☐ No If yes, when? What were the results?
Has (s)he received OT services: Currently? ☐ In the past? ☐ If yes, where?
Do you have any questions about fine motor skills that you think requires an OT evaluation now? ☐ Yes ☐ No If yes, please specify question(s):

Gross Motor Skills:

Does your child have any **gross motor** problems (walking, running, bike riding etc.)? ☐ Yes ☐ No Specify:
Does your child use any special equipment (wheel chair, braces, etc..)? ☐ Yes ☐ No **Specify:**
Has (s)he ever had an Physical Therapy (PT) evaluation? ☐ Yes ☐ No If yes, when? What were the results?
Has (s)he received PT services: Currently? ☐ In the past? ☐ If yes, where?
Do you have any questions about gross motor skills that you think requires an PT evaluation now? ☐ Yes ☐ No If yes, please specify question(s):

Vision:

Does your child have: Trouble seeing at a distance? ☐ Yes ☐ No Wear glasses for distance? ☐ Yes ☐ No Trouble seeing up close? ☐ Yes ☐ No Wear glasses for reading? ☐ Yes ☐ No Ever been to an eye doctor? ☐ Yes ☐ No Most recent date:

Do you feel your child has/had any of the following symptoms/problems *more than is typical for his/her age*?

Often defies adult rules: Currently ☐ In the past ☐	Difficulty keeping friends: Currently ☐ In the past ☐
Often angry/resentful:	Poor social interactions: Currently ☐ In the past ☐
Often argues with adults: Currently ☐ In the past ☐	Excessive preoccupations with ideas or objects: Currently ☐ In the past ☐
Often loses temper: Currently ☐ In the past ☐	Strange or bizarre ideas: Currently ☐ In the past ☐

Blames others for mistakes: Currently ☐ In the past ☐	Gets upset by changes in routine: Currently ☐ In the past ☐
Refuses to go to school: Currently ☐ In the past ☐	Prefers to play alone: Currently ☐ In the past ☐
Often bullies/threatens: Currently ☐ In the past ☐	Unusual eye contact: Currently ☐ In the past ☐
Initiates physical fights: Currently ☐ In the past ☐	Awkward in conversation: Currently ☐ In the past ☐
Often truant from school: Currently ☐ In the past ☐	Does not play in imaginative, pretend manner: Currently ☐ In the past ☐
Cruel to animals: Currently ☐ In the past ☐	Overreacts to noise or touch: Currently ☐ In the past ☐
Destroys property: Currently ☐ In the past ☐	Extreme mood swings: Currently ☐ In the past ☐
Deliberately sets fires: Currently ☐ In the past ☐	Often irritable: Currently ☐ In the past ☐
Lies often: Currently ☐ In the past ☐	Depressed mood: Currently ☐ In the past ☐
Steals: Currently ☐ In the past ☐	Often sad/cries easily: Currently ☐ In the past ☐
Frequent nightmares: Currently ☐ In the past ☐	Sleep problems: Currently ☐ In the past ☐
Excessive anxiety: Currently ☐ In the past ☐	Thinks about death: Currently ☐ In the past ☐
Panic attacks/unusual fears: Currently ☐ In the past ☐	Thinks or talks about suicide: Currently ☐ In the past ☐
Somatic complaints (headaches, stomachaches): Currently ☐ In the past ☐	Self-injurious behaviors (e.g., cutting): Currently ☐ In the past ☐
Repeats certain actions: Currently ☐ In the past ☐	Uses alcohol/drugs: Currently ☐ In the past ☐
Can't stop thinking about things: Currently ☐ In the past ☐	Motor or vocal tics: Currently ☐ In the past ☐

Please place a check mark in the column that best describes your child:

	Not at all	Just a little	Pretty much	Very much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate)				
2. Often has difficulty sustaining attention in tasks or play Activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).				

3. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).				
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily side-tracked).				
5. Often has trouble organizing tasks and activities (e.g., difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).				
6. Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (e.g., schoolwork or homework; for older adolescents & adults, preparing reports, completing forms).				
7. Often loses things necessary for tasks and activities (e.g. school materials, books, tools, wallets, keys, paperwork, glasses, cell phones).				
8. Is often easily distracted by extraneous stimuli (for older adolescents & adults, may include unrelated thoughts).				
9. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents & adults, returning calls, paying bills, keeping appointments).				
10. Often fidgets with or taps hands or feet, or squirms in seat.				
11. Often leaves seat in situations when remaining seated is expected (e.g., leaves place in classroom, in office, or in other situations that require remaining in place).				
12. Often runs about or climbs excessively in situations where it is inappropriate (**Note:** in adolescents or adults, feeling restless).				
13. Often unable to play or take part in leisure activities quietly.				
14. Is often "on the go," acting as if "driven by a motor" (e.g., unable to be or uncomfortable being still for extended time, as in restaurants, meetings; experienced by others as difficult to keep up with).				
15. Often talks excessively.				
16. Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait turn in conversation).				
17. Often has trouble waiting his/her turn (e.g., while waiting in line).				
18. Often interrupts or intrudes on others (e.g., butts into conversations or activities; may use other people's things without asking; for adults & adolescents, may intrude into or take over what others are doing).				

In your own words, please describe your concerns, and add any additional information that you feel is important and may be helpful in our assessment:

What **specific** questions do you have that you hope an evaluation will answer?

Signature of person completing this form:	Relationship to patient/child:	Date:

IMPORTANT: If your child is taking medication for attention problems (ADD, ADHD), please talk to the clinician evaluating him/her prior to the testing appointment to discuss whether (s)he should take the medication the day of the appointment.