



Neurodevelopmental Clinic

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 a number of clinical areas, such as Speech and 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:

1. Please complete and return the attached **Intake Form** *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).

2. 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. Also 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.
3. Once authorization is obtained, the actual evaluation will be scheduled. The testing appointment is typically scheduled 2 to 4 weeks after the initial meeting.
- A. **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.**
 - B. 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.
 - C. 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.
 - D. 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
 MassGeneral for Children
 at North Shore Medical Center
 57 Highland Avenue
 Salem, MA 01970
 Or FAX to: (978) 740-4960

Questions?

Call: (978) 354-2705

NSMC Neurodevelopmental Clinic

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

History-Intake Form

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

Payor Information (please check one):

Insurance <input type="checkbox"/>	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 <input type="checkbox"/>	NOTE: <i>If asking school to pay, please include a letter of agreement from school.</i>
Self-pay <input type="checkbox"/>	

Who referred you?:

Name:	Connection to Patient:
Agency (if applicable):	Phone #:
Do we have your permission to contact this person if necessary? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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):
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Family Information:

Name	Relationship to patient	Occupation or Grade:	Living with the patient?
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>

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:
<input type="checkbox"/> Attention Problems/ Hyperactivity		
<input type="checkbox"/> School Difficulties/ Learning Disabilities		
<input type="checkbox"/> Emotional Problems (e.g., Depression, Anxiety)		
<input type="checkbox"/> Autism/PDD Asperger's syndrome		
<input type="checkbox"/> Communication/ Language Problems		
<input type="checkbox"/> Social Difficulties		
<input type="checkbox"/> Alcoholism or Substance Abuse		
<input type="checkbox"/> Mental Retardation		
<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Take any drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Smoke cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No		Take any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was this an In Vitro fertilization? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Birth was: Normal <input type="checkbox"/>		Cesarean <input type="checkbox"/> Breech <input type="checkbox"/> Multiple Births <input type="checkbox"/>	
Birth weight:	Full term? <input type="checkbox"/> Yes <input type="checkbox"/> No If premature, how many weeks early?		
Were there any complications? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please specify:			

Early Developmental History:

Were there any problems in the first year of life? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please specify:

During the first 12 months, was this child:

Difficult to feed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Easy to comfort? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Difficult to get to sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No	Alert? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Difficult to put on a schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cheerful? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Colicky? <input type="checkbox"/> Yes <input type="checkbox"/> No	Affectionate? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Overactive/in constant motion? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sociable? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How old was child when (s)he:	Age	If not sure of age, please estimate if:		
Walked:		Early <input type="checkbox"/>	Average <input type="checkbox"/>	Late <input type="checkbox"/>
Said first words:		Early <input type="checkbox"/>	Average <input type="checkbox"/>	Late <input type="checkbox"/>
Began using sentences:		Early <input type="checkbox"/>	Average <input type="checkbox"/>	Late <input type="checkbox"/>
Toilet trained:		Early <input type="checkbox"/>	Average <input type="checkbox"/>	Late <input type="checkbox"/>

Has s(he) ever had:

Chronic ear infections <input type="checkbox"/> Yes <input type="checkbox"/> No	Lead poisoning <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	Head injury or concussion <input type="checkbox"/> Yes <input type="checkbox"/> No
Has s(he) ever had any serious illness or hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(If yes, please describe:)	

Medical Information:

Name of Pediatrician:	Telephone #:
Address:	
Is this child generally in good health? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please describe:)	
Does this child have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which grade:	Is there an IEP? <input type="checkbox"/> 504 plan? <input type="checkbox"/>	Are you appealing it?: <input type="checkbox"/> Yes <input type="checkbox"/> No
Has (s)he ever received any special/extra help in school? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is (s)he <i>currently</i> receiving any special/extra help in school?: <input type="checkbox"/> Yes <input type="checkbox"/> No	

If yes, please check off type of services received:

Reading <input type="checkbox"/>	Resource Room <input type="checkbox"/>	In-class help <input type="checkbox"/>	Separate class <input type="checkbox"/>	Aide <input type="checkbox"/>
Occupational Tx <input type="checkbox"/>	Physical Tx <input type="checkbox"/>	Speech/Language Tx <input type="checkbox"/>	Counseling <input type="checkbox"/>	
Other (specify):				
Has (s)he ever had a developmental, psychological, neuropsychological or educational (CORE) evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, Agency: _____ Therapist: _____		
Phone #: _____		Reason: _____
Is there any DCF or DYS involvement? No <input type="checkbox"/> Yes: Now <input type="checkbox"/> In the past <input type="checkbox"/>		

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 <input type="checkbox"/> Signs <input type="checkbox"/> Gestures <input type="checkbox"/>		
Does your child have any: Hearing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has (s) ever had an Audiology evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, when? _____ What were the results? _____		
Does (s)he have any problems understanding what is said to him/her? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does (s)he have any speech problems/difficulty speaking? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has (s)he ever had a Speech & Language evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, when? _____ What were the results? _____		
Has (s)he received Speech & Language therapy: Currently? <input type="checkbox"/> In the past? <input type="checkbox"/>		
If yes, where? _____		
Do you have any concerns about his/her speech/language that you think requires a Speech/Language evaluation now? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please Elaborate: _____		

Fine Motor Skills:

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

Gross Motor Skills:

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

Vision:

Does your child have:	
Trouble seeing at a distance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Wear glasses for distance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble seeing up close? <input type="checkbox"/> Yes <input type="checkbox"/> No	Wear glasses for reading? <input type="checkbox"/> Yes <input type="checkbox"/> No
Ever been to an eye doctor? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> In the past <input type="checkbox"/>	Difficulty keeping friends: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Often angry/resentful:	Poor social interactions: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Often argues with adults: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Excessive preoccupations with ideas or objects: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Often loses temper: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Strange or bizarre ideas: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Blames others for mistakes: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Gets upset by changes in routine: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Refuses to go to school: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Prefers to play alone: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Often bullies/threatens: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Unusual eye contact: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Initiates physical fights: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Awkward in conversation: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Often truant from school: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Does not play in imaginative, pretend manner: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Cruel to animals: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Overreacts to noise or touch: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Destroys property: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Extreme mood swings: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Deliberately sets fires: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Often irritable: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Lies often: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Depressed mood: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Steals: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Often sad/cries easily: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Frequent nightmares: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Sleep problems: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Excessive anxiety: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Thinks about death: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Panic attacks/unusual fears: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Thinks or talks about suicide: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Somatic complaints (headaches, stomachaches): Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Self-injurious behaviors (e.g., cutting): Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Repeats certain actions: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Uses alcohol/drugs: Currently <input type="checkbox"/> In the past <input type="checkbox"/>
Can't stop thinking about things: Currently <input type="checkbox"/> In the past <input type="checkbox"/>	Motor or vocal tics: Currently <input type="checkbox"/> In the past <input type="checkbox"/>

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).				

