NEUROPSYCH ASSESSMENTS OF GREATER BOSTON

Intake Form

Identifying Information

1 **Child's Name:** ..... Age: ..... Date of Birth: .....

2 Address (City, State and Zip): .....

3 Insurance Name: .....

4 Insurance Number: .....

5 **Mother's Name:** .....

6 Address (if different): .....

7 Phone: *(home)* ..... *(work)* ..... *(cell)* .....

8 **Father's Name:** .....

9 Address (if different): .....

10 Phone: *(home)* ..... *(work)* ..... *(cell)* .....

11 **Step Parent/ Guardian** .....

12 Address (if different): .....

13 Phone: *(home)* ..... *(work)* ..... *(cell)* .....

Referral Information

14 **Who referred you?:** .....

15 Connection to Child: .....

16 Agency name: ..... Tel: .....

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Issue of Concern

17 Please describe your main concern or question: .....

.....

.....

.....

18 What have you been told by doctors, teachers or others about your concern?

.....

.....

.....

19 Has your child been given a diagnosis? Yes No

20 When when were they last evaluated/ diagnosed? .....

21 By whom? .....

22 What was the diagnosis? .....

Family Information

	Name	Relationship to child	Occupation or School grade & age	Living with child?	
23	1	.....	.....	Yes	No
24	2	.....	.....	Yes	No
25	3	.....	.....	Yes	No
26	4	.....	.....	Yes	No
27	5	.....	.....	Yes	No

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Marital Status: *Married* *Seperated* *Divorced* *Single* *Unmarried/ living together*

If separated or divorced, with whom is your child living? What is the custody arrangement?

.....

Who has legal custody? .....

How does each parent discipline? .....

What is the child's residence? Apartment Single home Other: .....

Has your child experienced a separation, divorce or death? Yes No

If yes, when/ who? .....

Age of your child at the time? .....

Child's reaction? .....

Family Medical History

Please identify any of your child's biological relatives (i.e. brother, sister, parent, uncle, aunt, cousin, grandparent) who have had any of the following conditions:

	Condition	Relationship to child	Additional Detail
1	Attention Problems/ Hyperactivity		
2	School Difficulties/ Learning Difficulties		

Condition	Relationship to child	Additional Detail

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41	3	Emotional/ Psychiatric Issues	.....	.....
42	4	Autism/ PDD/ Asperger's Syndrome	.....	.....
43	5	Communication/ Language Issues	.....	.....
44	6	Social Difficulties	.....	.....
45	7	Alcoholism/ Substance Abuse	.....	.....
46	8	Mental Retardation	.....	.....
47	9	Seizure Disorder	.....	.....
48	10	Other	.....	.....

49 Does your child remind you of any of the above noted relatives? Please provide detail.

.....

.....

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Pregnancy and Birth History

During Pregnancy, did mother: *(please circle yes/no)*

Drink alcohol? No Yes If yes, how frequent? .....

Smoke cigarettes? No Yes If yes, how frequent? .....

Take any drugs? No Yes If yes, which ones/ how frequent? .....

Take any medications? No Yes If yes, which ones/ how frequent? .....

.....

Birth was: Vaginal Cesarean Breech Multiple Births

Birth weight: .....

Full Term? Yes No If premature, how many weeks early? .....

Were there any complications? No Yes If yes, please explain .....

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 your child: *(please circle yes or no)*

Difficult to feed? Yes No

Difficult to get to sleep? Yes No

Difficult to put on a schedule Yes No

Easy to comfort? Yes No

Alert Yes No

Cheerful Yes No

Colicky Yes No

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Affectionate	Yes	No	
Overactive/ In constant motion	Yes	No	
Sociable	Yes	No	

How old was your child when they: Age If not sure of age, please estimate if:

(Circle one)

Walked	.....	Early	Average	Late
Said first words	.....	Early	Average	Late
Began using sentences	.....	Early	Average	Late
Toilet trained	.....	Early	Average	Late

Had they ever had: *(please circle yes or no)*

Chronic ear infections	Yes	No
Seizures	Yes	No
Lead poisoning	Yes	No
Head injury or concussion	Yes	No

Had they ever had any serious illness or hospitalization Yes No

If yes, please explain: .....

Behavior/ Mental Health

Does your child currently receive any mental health services (therapy, counseling, etc..)? Yes No

If yes, with which agency? .....

Therapist .....

Telephone # .....

Reason .....

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Has your child seen a therapist in the past?

If yes, please explain .....

Therapist .....

Telephone # .....

Reason .....

Is there any current DSS involvement? Yes No

If yes, please explain. .....

Has there been any DSS involvment in the past? Yes No

If yes, please explain. .....

Social History

Does your child have friends in school? Yes No

Does your child have friends outside of school (i.e. neighborhood, afterschool activities, camp) Yes No

Does your child have difficulty making friends? Yes No

If yes, why? .....

Does your child have difficulty keeping friends? Yes No

If yes, why? .....

Does your child prefer to play alone? Yes No

Does your child prefer to play with younger children? Prefers to be with adults? Yes No

Are you concerned with the behavior/habits of your child's friends (i.e. smoking, school tardiness, staying out late, substance use, risky behavior)? Yes No

What activities does your child enjoy (or do well)? .....

Has your child's interest in these activities declined recently? Yes No

If yes, please explain? .....

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Educational Information

Name of Current School: _____ Grade: _____

Tele: _____ Address: _____

Teacher or school contact: _____

Has (s)he ever repeated a grade: _____ Yes No

If yes, which grade? _____

Is there an I.E.P.? No Yes If yes, date of last meeting _____

Is there a 504 plan? No Yes

Is the child receiving any extra help or accommodations at school? Yes No

If yes, please explain: _____

Has the child received extra/ special help in the past? Yes No

If yes, please explain: _____

If child does (or has) received services, please specify:

Reading _____

Resource Room _____ Aide _____

In-Class help _____ Occupational Therapy _____

Separate Class _____ Physical Therapy _____

Counseling _____ Speech/Language Therapy _____

Other *(please explain)* _____

Has the child ever had a developmental, psychological, neuropsychological or educational (CORE) evaluation?

If yes, please when? _____

Where? With Whom? _____

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Have you requested, or is your child scheduled to be tested through the school in the near future (i.e. CORE evaluation)?

If yes, please when? .....

Please describe your child's academic abilities in the following subjects; is (s)he at, above or below grade level? Please describe:

	Above Grade Level	At grade Level	Below Grade Level
Math:	.....	.....	.....
Reading:	.....	.....	.....
Writing:	.....	.....	.....
Spelling:	.....	.....	.....

Approximately how many school days has your child missed this year? .....

Last year? .....

Does your child's current functioning interfere with their participation in school?

.....

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

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Fine Motor Skills:

Does your child have fine motor problems (i.e. writing, drawing, pencil grasp)?

If yes, please specify: .....

Has (s)he ever had an Occupational Therapy (OT) evaluation?

If yes, when? .....

Results? .....

Has (s)he received OT services? ..... Currently ..... In the past

If yes, where? .....

Please elaborate on any problems/concerns in this area: .....

.....

Gross Motor Skills:

Does your child have any gross motor problems (i.e. walking, running, bike riding)?

If yes, please specify: .....

Does your child use any special equipment (i.e. wheel chair, braces)?

If yes, please specify: .....

Has (s)he ever had a Physical Therapy (PT) evaluation?

If yes, when? .....

Results? .....

Has (s)he received PT services? ..... Currently ..... In the past

If yes, where? .....

Please elaborate on any problems/concerns in this area: .....

.....

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Vision

Does your child have:

Trouble seeing at a distance?	yes	no .....
Trouble seeing up close?	yes	no .....
Ever been to an eye doctor?	yes	no .....
When?	.....	
Wear glasses for distance?	yes	no .....
Wear glasses for reading?	yes	no .....
If yes, since when?	.....	

Survey of Symptoms/ Problems

Do you feel your child has/had any of the following symptoms/problems more than is typical for his/her age? If not, please leave question blank.

	Currently	In the past
Often defies adult rules:	.....	.....
Often angry/resentful:	.....	.....
Often argues with adults:	.....	.....
Often loses temper:	.....	.....
Blames others for mistakes:	.....	.....
Refuses to go to school:	.....	.....
Frequent nightmares:	.....	.....
Excessive preoccupation with ideas of objects:	.....	.....
Uses alcohol/drugs:	.....	.....
Often bullies/threatens:	.....	.....
Initiates physical fights:	.....	.....
Often truant from school:	.....	.....
Cruel to animals:	.....	.....
Destroys property:	.....	.....
Deliberately sets fires:	.....	.....
Difficulty keeping friends:	.....	.....

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	Currently	In the past
Self-injurious behaviors:		
Can't stop thinking about things:		
Overreacts to noise or touch:		
Poor social interactions:		
Extreme mood swings:		
Often irritable:		
Depressed mood:		
Often sad/cries easily:		
Sleep Problems:		
Repeats certain actions:		
Gets upset by changes in routine:		
Excessive anxiety:		
Lies often:		
Thinks about death:		
Panic attacks/ Unusual Fears		
Steals:		
Thinks about or talks about suicide:		
Somatic complaints (headaches, stomach aches):		
Strange or bizarre ideas:		
Motor or vocal tics		

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, work or other activities				
2. Often has difficulties sustaining attention in tasks or play activities				
3. Often does not seem to listen when spoken to				
4. Often does not follow through on instructions and fails to finish schoolwork or chores (not due to oppositional behavior or failure to understand instructions)				

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	Not at all	Just a little	Pretty much	Very Much
5. Often has difficulty organizing tasks and activities				
6. Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (i.e. homework)				
7. Often loses things necessary for tasks or activities (i.e. toys, school assignments, pencils, books or tools)				
8. Is often easily distracted by extraneous stimuli				
9. Is often forgetful in daily activities				
10. Often fidgets with hands or feet, or squirms in seat				
11. Often leaves seat in classroom or other situations in which remaining seated is expected (i.e. dinner table)				
12. Often runs about or climbs excessively in situations where it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)				
13. Often has excessive difficulty playing or engaging in leisure activities quietly				
14. Is often “on the go” or acts as if “driven by a motor”				
15. Often talks excessively				
16. Often blurts out answers before questions have been completed				
17. Often has difficulty waiting their turn				
18. Often interrupts or intrudes on others (i.e. butts into conversation or games)				

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

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

Signature of person completing this form: _____

Relationship to child: _____

Date: _____

Important: If your child is taking medication for attention problems (ADHD), please contact NAGB prior to the testing appointment to discuss whether (s)he should take the medication the day of the appointment.

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