Boston Children's Hospital
Learning Disabilities Program

LEARNING DISABILITIES PROGRAM
INTAKE FORM

We must have <u>all</u> of the following documents in order to review your child's needs and schedule the appointment.

Please check boxes below.

- ☐ This Intake Form
- ☐ Copies of the front and back of insurance card
- ☐ Previous testing if applicable
- ☐ IEP if applicable
- ☐ Therapist Form if applicable

In the space below, please provide the following:

The email address of your child's teacher who spends the most time in school with them and grade taught (if child is in middle school, please provide information for ELA and math teachers)

_____

_____

The name of your child's primary care physician, and the approximate date of last visit

_____

_____

Testing History

Indicate if your child has had the following by selecting Yes, No, Unknown

1. Has your child had any prior testing? select

2. School testing……. select Dates of testing: _____

Please submit all school testing completed in the last three years

a. IEP……. select
b. 504……. select

3. Testing completed outside school……. select
(e.g. Neuropsychological, Occupational Therapy)

Please submit all testing completed outside school

Boston Children's Hospital
Learning Disabilities Program

Learning Disabilities Program
Department of Neurology
Boston Children's Hospital 300
Longwood Avenue BCH3443
Boston, MA 02115

Phone: (617) 355-2868
Fax: (617)-730-4795

Intake Form

Today's Date _____

Child's Full Name _____ Date of Birth _____

Child's Sex _____ Telephone (Home) _____

Child's Pronoun Select Telephone (Cell) _____

Your Full Name and Relationship to Child _____

Email: _____

Home Address _____

_____

Name of current School and School for year 2023-2024 if different _____ Grade _____

_____

Teacher(s) _____

Is this a re-evaluation with Boston Children's Hospital Learning Disabilities Program? Yes

If so, what year was your child's evaluation? _____ ___

Whose idea was this evaluation? _____

What are you hoping to gain from this evaluation?

What specific questions do you have?

A. BIRTH HISTORY

☐ Unknown (skip to page 3)

Is your child adopted? Y / N No If yes, age at adoption _____

Which of the mother's pregnancies was this (1st, 2nd, 3rd, etc.)? _____

Were there miscarriages prior to this pregnancy? NO ☐ YES ☐ How many? _____

Were there therapeutic abortions prior to this pregnancy? NO ☐ YES ☐ How many? _____

Age of mother at delivery: _____

Age of father at delivery (if known): _____

During Pregnancy:

☐ Unknown (skip to page 3)

Circle Y (yes) or N (no) if the following occurred. If Y (yes), please list or describe.

Illness..... Select Describe _____

Medication taken.... Select Describe _____

Bleeding ..... Select Describe _____

Smoking ..... Select If YES, how much? _____

Alcohol intake ..... Select If YES, how much? _____

Weight Gain in Pounds: _____

Length of Pregnancy in Months: _____

Labor:

Induced..... Select If YES, give reason _____

Lasted over 12 Hours ..... Select

Delivery:

Cesarean Section ..... Select If YES, give reason _____

Anesthesia ..... Select If YES, what type: Spinal ☐ Epidural ☐ General (asleep) ☐

Newborn:

Birth Weight:

Cried right away..... Select

Complications ..... Yes If YES, please describe _____

Went home after _____ days in the hospital

Apgar score, if known _____

Infancy:

Enjoyed cuddling..... Select Fussy, Irritable Yes

More active than other babies Select Other:

B. DEVELOPMENTAL HISTORY

If you can recall it, record the age at which your child reached the following developmental milestones. If you cannot recall the age, check an item at right.

		I cannot recall exactly, but to the best of my recollection it occurred:			
	Estimate	Early	At normal time	Late	Not known
Sat without support					
Crawled					
Stood without support					
Walked without assistance					
Spoke first words besides "mama" and "dada"					
Said phrases					
Said sentences					
Spoke clearly					
Showed clear hand preference					
Bowel trained					
Bladder trained, day					
Bladder trained, night					
Rode tricycle					
Rode bicycle (without training wheels)					
Buttoned clothing					
Tied shoelaces					
Named colors					
Named coins					

Current Performance:
How well does your child function in the following areas compared with age peers? (please check box)

	About like peers	Better than peers	Worse than peers
Walking			
Running			
Throwing			
Catching			
Athletic Abilities			
Understanding Directions			

What are some of your child's favorite activities?

1. _____
2. _____
3. _____
4. _____
5. _____

Does s/he belong to any teams, clubs or participate in group activities? ◯ Yes ◯ No

If yes, which? _____

_____

How many friends does your child have? _____

Approximately how often does your child get together with friends? _____

How does your child get along with

Siblings (if applicable)? _____

_____

_____

Peers? _____

_____

_____

Parents? _____

_____

_____

Other adults? _____

_____

_____

C. MEDICAL HISTORY

Indicate if your child has had the following by selecting Yes or No.

For adopted children: age at which known medical history begins: _____

1. Ear infections	1. Select	If yes, starting at what age? _____
2. Were tubes ever put in place?	2. Select	
3. Were antibiotics ever given to prevent ear infections?	3. Select	
4. Hearing problems	4. Select	
5. Vision Problems	5. Select	
6. Allergies	6. Select	If yes, to what? _____
7. Headaches	7. Select	
8. Stomach Aches	8. Select	
9. Heart, lung or kidney problems	9. Select	
10. Muscle, bone or joint problems	10. Select	
11. Serious Head Injury	11. Select	If yes, at what age? _____
12. Did child lose consciousness?	12. Select	
13. Surgery	13. Select	If yes, for what? _____
14. Hospitalization	14. Select	If yes, at what age? _____

Reason: _____

Lead level in blood testing Select Date(s):_____ Numerical value: _____

(This information may be obtained from your pediatrician if you do not have it)

Has your child fainted or passed out DURING exercise, emotion or startle?	Select
Has your child fainted or passed out AFTER exercise?	Select
Has your child had extreme fatigue associated with exercise (different from other children)?	Select
Has your child ever had unusual or extreme shortness of breath during exercise?	Select
Has your child ever had discomfort, pain or pressure in his chest during exercise?	Select
Has your child ever been diagnosed with an unexplained seizure disorder?	Select
Has your child ever had heart surgery or a cardiac catheterization?	Select
Has your child ever been seen by a cardiologist?	Select
Does your child either currently see a cardiologist or have a cardiac diagnosis?	Select

List any medical or psychological diagnoses: (e.g. ADHD, Autism, Anxiety disorder) that your child has:

1. _____
2. _____
3. _____

List any medications, with doses, child takes at present and include the name of the prescribing physician:

_____

_____

_____

List dates of any private counseling or psychotherapy child or family have received related to child's difficulties:

_____

_____

_____

Please note any problems with:

Sleep: _____

Appetite: _____

Undesirable behaviors or habits:

_____

_____

Self-esteem: _____

If applicable, name of recent private counselor/therapist: (complete separate therapist form if applicable)

_____

Describe your child's personality:

_____

_____

_____

What are your greatest concerns about your child's social, emotional or behavioral development?

_____

_____

_____

What are your child's most notable strengths?

_____

_____

_____

_____

D. FAMILY HISTORY

Child lives with (check all that apply):

- ☐ Birth Mother
- ☐ Birth Father
- ☐ Stepmother
- ☐ Stepfather
- ☐ Adoptive Mother
- ☐ Adoptive Father
- ☐ Foster Mother
- ☐ Foster Father
- ☐ Another relative_____
- ☐ Other _____

If child is adopted, please indicate age at adoption:_____

Current Living Situation:

Language spoken at home:_____

Parent 1	**Parent 2 (if applicable)**
Name:_____	Name:_____
Age:_____	Age:_____
Occupation:_____	Occupation:_____
Relationship to child: _____	Relationship to child:_____
Highest level of education completed: _____	Highest level of education completed:_____
Learning problems:_____	Learning problems:_____
Behavior problems:_____	Behavior problems:_____
Medical problems (specify):_____	Medical problems (specify):_____
Emotional problems:_____	Emotional problems:_____
Drug or alcohol abuse:_____	Drug or alcohol abuse:_____

Parents are (check all that apply):

- ☐ Married
- ☐ Domestic Partners
- ☐ Living Together
- ☐ Separated
- ☐ Divorced
- ☐ Never Married
- ☐ Mother deceased
- ☐ Father deceased
- ☐ Living Apart

Other members of the Household (beyond those mentioned above)**:**

☐ **NONE**

Name	Age	Relation to child (ex. Sibling)	Medical, social, academic problems

Birth Family (or parents not living with child):

☐ **Same as above**

☐ **Unknown.**

Parent 1

Name:_____

Age:_____

Relationship to child: _____

Occupation:_____

Highest school grade completed:_____

Learning problems:_____

Behavior problems:_____

Medical problems (specify):_____

Emotional problems:_____

Drug or alcohol abuse:_____

Parent 2 (if known)

Name:_____

Age:_____

Relationship to child: _____

Occupation:_____

Highest school grade completed:_____

Learning problems:_____

Behavior problems:_____

Medical problems (specify):_____

Emotional problems:_____

Drug or alcohol abuse:_____

Siblings living outside the household (if applicable)**:**

☐ **NONE**

Name	Age	Relationship to child (ex: half-brother, step-sister)	Place of residence (ex. Away at college)	Medical, social, academic problems

Please list any relatives on either side of the family who have had the following:

	Relationship to child	Mother's side	Father's side
Behavior problems, including hyperactivity			
Emotional Problems			
Drug or alcohol abuse			
Learning problems			
Ambidexterity or left-hand preference			
Migraine headaches			
Intellectual disability			
Childhood diabetes			
Colitis			
Lupus erythematosus			
Rheumatoid arthritis			
Thyroid disease			
Other "immune" disease			
Seizures or epilepsy			
Lead poisoning			
Other neurological problems			

Are there any family members who had an unexpected, unexplained death before age 50? Select

(Include SIDS, car accident, drowning, others) Select

Are there any family members who died of heart problems before age 50? Select

Are there any family members who have had unexplained fainting or seizures? Select

E. Please explain any "yes" answers here and add any other information you feel would be helpful.

Financial Information

Your first payment is due AT THE TIME OF SCHEDULING. Payment can be made over the phone by Visa, Mastercard, Discover, or American Express.

****We cannot schedule your child's evaluation without the initial payment.****

Prices are subject to review and adjustment. Please contact the office by phone at 617-355-2868 for current rates and an estimated partial payment amount.

1. **Insurance Coverage Information:**

Claims are submitted by the CH Neurology Foundation Inc. under tax ID 22-2678594 Each component is billed separately.

Child's Name:_____ Date of Birth: _____

Person responsible for any financial liability:

Name and Phone number: _____

Subscriber's Name and D.O.B.:_____

Name of the insurance company: _____

Plan ID #/ Group #:_____

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

Guarantor Financial Commitment

A guarantor must be designated to assume financial responsibility for the costs associated with the evaluation. The guarantor cannot be an insurance company or public school system. Theguarantor should be the one to complete and sign this form.
To guarantors: please complete this form and return it along with the required background materials if interested in scheduling an evaluation. **Please note: the evaluation cannot be scheduled unless this completed form is received by the office.**

Child's full name: _____

Child's date of birth: _____

Guarantor's full name: _____

Guarantor's date of birth: _____

The Children's Neurology Foundation may bill the child's insurance company for the following components below and may be processed based on your insurance plan coverage and this does not include the educational components that are not billable to insurance (Speech, Math, Reading and Coordination). These charges will be self-pay or may be school funded if contract is received.

- Neurologic Examination
- Neuropsychological Testing
- Psychological Testing

I understand that coverage from my child's insurance company is contingent upon eligibility on the date of service. I understand that I am financially responsible for any co-payments, deductibles, or co-insurance that may arise from billing the child's insurance plan for the components checked off in the list above. I understand that if the insurance company is billed for a service but denies the claim, I am responsible for the full cost of the service. I understand that the educational components are not billable to insurance (Speech/Oral language, Math, Reading/Written Language and Coordination). These charges will be self-pay or school funded, if a contract is received.

_____

Signature of guarantor Date

Boston Children's Hospital

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

0 is automatically selected, click into bubble to answer accordingly

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

Please return this form to:

Boston Children's Hospital
Learning Disabilities Program

E-mail:
LDProgram@childrens.harvard.edu

Fax: 617-730-4795