Children's National Health System
Division of Pediatric Neuropsychology
Center for Autism Spectrum Disorders
Mail: 15245 Shady Grove Road, Suite 350, Rockville, MD 20850
Fax: 301-765-5470

Instructions: The following information helps us to appropriately schedule your appointment and request insurance authorization. Please answer all of the following questions as best you can and **return via email** (NeuroPsychIntake@childrensnational.org) **with all recent psychological, educational, and speech-language evaluations and current IEP.** You also may fax or mail the intake and supporting documents if you do not have access to email or are unable to scan your documents. If you have any questions, please call 301-765-5430. **Please note evaluation services are not advisable when there are acute concerns for your child's well-being. If you have immediate concerns related to your child's safety, please seek emergency psychiatric services at your nearest emergency room.**

Today's Date:_____

Patient Name: _____ Date of Birth: _____Age: _____ Sex: _____

Who referred the patient to us?

☐A doctor or healthcare provider: Name_____ Telephone number:_____

Doctor's specialty (e.g., pediatrician, neurologist, psychologist, psychiatrist) _____

☐Self-referred ☐Teacher/ someone at school ☐Insurance company ☐Other_____

To which service were you referred? ☐Neuropsychology ☐Autism Center ☐Both ☐Not sure

Would you like to request a particular doctor? Name: _____

Why are you seeking an evaluation? What are your current concerns or questions?

Please check all medical conditions your child has or has had:

☐	Brain Tumor: _____	☐	Prematurity: weeks of pregnancy_____
☐	Leukemia: _____	☐	Hydrocephalus
☐	Stroke: date_____	☐	Genetic Disorder: _____
☐	Mild Traumatic Brain Injury (Concussion): date: _____	☐	Neurofibromatosis
☐	Moderate-Severe Traumatic Brain Injury: date _____	☐	Congenital Heart Disease
☐	CNS Infection (e.g. meningitis, encephalitis): _____	☐	Sickle Cell Disease
☐	Epilepsy/Seizure Disorder: _____	☐	Other medical condition (s):_____

Patient Name:_____

Check any diagnoses that the patient has or is suspected to have. *Check "Suspected" for any diagnosis you would like us to test for, give a second opinion about, or "rule out."*

Yes (Child has)	Suspected (Child might have)	Condition
☐	☐	ADHD/ADD (Attention disorder)
☐	☐	Autism (e.g. ASD, Asperger's Disorder, PDD-NOS)
☐	☐	Learning Disability
☐	☐	Language Delay or Language Disorder
☐	☐	Intellectual Disability (formerly Mental Retardation)
☐	☐	Depression/ Mood Disorder – Describe:
☐	☐	Anxiety Disorder - Describe:
☐	☐	Gender Concerns, Gender Dysphoria, or Gender Nonconformity
☐	☐	Other:

Please list any other testing that has been done (Neuropsychological, psychological/ IQ, educational, speech/language)

Type of testing	Date completed	By whom?

Is any **other testing planned or scheduled** (including IEP testing at school, or other evaluations coming up)?
☐No ☐Yes (describe) _____

What is the name of the patient's school? _____ Grade?_____

Please check any areas where the patient is having problems in school:

☐	Reading
☐	Math
☐	Writing
☐	Executive Functioning, organization, study skills
☐	Other - Describe:

At school, does the patient receive:

☐	Special education services or an Individualized Educational Program (IEP)?
☐	Accommodations or a 504 Plan?

Patient Name:_____

Please check all *treatment* the patient receives (at school or privately):
☐ Speech Therapy ☐Occupational Therapy ☐Physical Therapy ☐Counseling/ Psychotherapy
☐ Psychiatric Treatment (date of last visit) _____ ☐ Other: _____

Has the patient ever had a psychiatric hospitalization or residential placement? ☐No ☐Yes (when?)_____

Please list any regular prescription medicines the patient takes:

Medication	Dose	Date started

Please indicate or estimate the patient's general level of cognitive functioning (IQ):
☐Above Average ☐Average ☐Below Average ☐ Intellectually Disabled

Please indicate if the patient has any of the following conditions:

☐	Hearing impairment (not corrected with hearing aids) – describe:
☐	Visual impairment (not corrected with glasses) – describe:
☐	Selective mutism (*does not speak in some situations, such as at school, but does speak in other situations, such as at home*)
☐	Serious psychiatric illness, psychosis – describe:
☐	Substance abuse – describe:

Is this patient involved in any legal actions or lawsuits? If yes, please explain: _____

Has this patient been in prison or placed in a detention center? If yes, please explain: _____

How does this patient communicate? ☐Sentences or more ☐ Phrases ☐Single words only ☐AAC or Signs ☐Other_____

What language(s) are spoken in the home? ☐English ☐Spanish ☐Other(s)_____

Does the patient speak: ☐Mostly (or all) English ☐Mostly (or all) another language:_____
☐A mix of languages ☐Other_____

If the patient speaks more than one language, when did she or he start speaking English?_____

If the patient speaks more than one language, does he or she receive ESOL/ELL (English for Speakers of Other Languages/English Language Learner) services at school? ☐No ☐Yes

Would you like an interpreter* for the parent interview? ☐No ☐Yes (Language)_____
**Interpreters are provided free of charge and will not delay scheduling of your appointment*

Patient Name:_____

How much are these issues a problem for this patient? Please check the best answer:

Cognitive Problems

Never	Some-times	Often	
☐	☐	☐	Poor attention/concentration, distractible, can't focus
☐	☐	☐	Poor memory: can't remember multi-step directions, forgets items at school/home
☐	☐	☐	Poor language skills: difficulty understanding or using language
☐	☐	☐	Poor spatial orientation abilities: gets lost easily, difficulty with left from right
☐	☐	☐	Poor organization, time management, planning; is scattered
☐	☐	☐	Difficulty being flexible in thinking: gets stuck on issues, repeats thoughts/ideas
☐	☐	☐	Poor fine motor skills: buttoning, zipping, tying shoes, handwriting
☐	☐	☐	Other cognitive/ thinking problems?

Behavioral / Emotional / Social Problems

Never	Some-times	Often	
☐	☐	☐	Overactive behavior; always on the go, fidgets, always climbing
☐	☐	☐	Impulsive behavior: acts without thinking, interrupts others, calls out in class
☐	☐	☐	Oppositional behavior: won't follow directions, is defiant, refuses to listen
☐	☐	☐	Difficulty with flexible behavior, insists things stay the same, trouble with transitions
☐	☐	☐	Emotional problems: ☐Anxious ☐Depressed ☐Withdrawn Behavior
☐	☐	☐	Aggressive behavior with: ☐Peers ☐Siblings ☐Parents ☐Other adults
☐	☐	☐	Emotionally reactive: has temper tantrums, gets easily upset / frustrated
☐	☐	☐	Social problems: trouble making friends or getting along with others
☐	☐	☐	Difficulty understanding social cues
☐	☐	☐	Unusual or repetitive behaviors (explain:)
☐	☐	☐	Overly intense or repetitive interests (explain:)
☐	☐	☐	Other behavior concerns?

Add any additional information or comments below:

Patient Demographic and Insurance Sheet

Patient's Name First:_____ Middle: _____ Last:_____

Date of Birth: _____ Sex:_____ Race:_____ Ethnicity: ☐Hispanic ☐Non-Hispanic

Home Address: _____
Street *City* *State* *Zip*

_____ Home Telephone:_____
Country

Patient's primary care doctor/ pediatrician: _____ Telephone: _____

Person filling out this form:
Name: _____ Relationship to patient: _____

Who should we contact to schedule the appointment?
Name: _____ Relationship to patient: _____
Home or cell phone number(s):_____ E-mail Address: _____

Is there an existing custody agreement for this patient? ☐No ☐Yes

If yes, please list all individuals who have legal custody of the patient: _____

Are there are any specific instructions in the custody order impacting who makes medical decisions for the child?

☐No ☐Yes If yes, please describe: _____

INSURANCE

Primary Guarantor: _____ Relationship to Patient: _____
Home Address: _____
Employer: _____ Work Telephone: _____
_____ Date of Birth: _____

Secondary Guarantor:_____ Relationship to Patient: _____
Home Address: _____
Employer: _____ Work Telephone: _____
_____ Date of Birth: _____

Method of Payment (check one):

☐Self Pay

☐Insurance company: _____
Address: _____
Telephone: _____
Policy #: _____
Group #: _____

OFFICE USE ONLY: Reviewed By: _____ Date: _____ Assign to:_____ ICD-10 Dx: _____

☐____SP-1 Academic Assessment ☐ SP-2 Social Cognition ☐ SP-3 NP Assessment ☐ SP-4 Psychological Assessment