Child Study Center
Cook Children's

Dear Parent/Guardian:

We are pleased that you are considering the services of Child Study Center for your child. In order to process your application, please provide ALL of the information requested below:

_____1. Child and Family Information
_____2. NICHQ Vanderbilt Assessment Scale – Parent Informant
_____3. School Questionnaire & Vanderbilt Scale – **from your child's current teachers**
_____4. Copy of Insurance Card – **both sides of card must be photocopied**
_____5. Copies of Custody Papers, if applicable. **Must contain judge's signature**
_____6. Other: **Copies of all previous educational testing and medical records related to developmental or behavioral testing**

We will be unable to schedule appropriate services for your child until ALL completed information has been received.

A Client Services specialist may be reached at **(682) 303-9300** for any questions regarding your application.

PLEASE NOTE:
After receiving all of your information, your application will be reviewed.
Child Study Center focuses on the evaluation and treatment of children with developmental disabilities. If your child's needs are not within the scope of our services, we will provide you with a list of appropriate community resources.

Mail completed application to:
Client Services Specialist
Child Study Center
1300 West Lancaster Avenue
Fort Worth, TX 76102

Visit us online at: www.cscfw.org

Child Study Center
Cook Children's

Patient's Initials ___

CHILD AND FAMILY INFORMATION

PLEASE PRINT IN BLACK INK

HAS THIS CHILD PREVIOUSLY BEEN SEEN AT CSC? □YES □NO TODAY'S DATE: _____

CHILD INFORMATION

LAST NAME_____FIRST_____MIDDLE_____
DATE OF BIRTH_____ AGE _____ GENDER ___ SS# ____ - ____ - _____ ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____ COUNTY_____
LENGTH OF TIME AT CURRENT ADDRESS_____ PRIMARY PHONE _____

ETHNICITY: □Hispanic or Latino □Not Hispanic or Latino

RACE: □American Indian or Alaska Native □Asian □Black or African American
□Native Hawaiian or Other Pacific Islander □White

LANGUAGE SPOKEN BY THE CHILD_____WILL YOU NEED A TRANSLATOR? □YES □NO
WHICH LANGUAGE SHOULD BE SPOKEN BY THE TRANSLATOR? _____

REFERRAL DOCTOR INFORMATION

CHILD REFERRED BY_____PHONE#_____
DOCTOR'S ADDRESS_____CITY_____STATE_____ZIP CODE_____

PARENT/GUARDIAN INFORMATION

WHO DOES THE CHILD LIVE WITH? _____
IS THIS THE LEGAL GUARDIAN? □YES □NO RELATIONSHIP TO CHILD_____

MOTHER/GUARDIAN FULL NAME_____MARITAL STATUS_____

DATE OF BIRTH_____SS#_____EMPLOYER_____

PRIMARY PHONE#_____ □ cell □ home OTHER PHONE#_____ □ cell □ home

EMAIL _____ □*YES, I would like to be added to your email list for updates about Child Study Center. I understand my information will be kept confidential, and I can unsubscribe at any time.*

FATHER/GUARDIAN FULL NAME_____MARITAL STATUS_____

DATE OF BIRTH_____SS#_____EMPLOYER_____

PRIMARY PHONE#_____□ cell □ home OTHER PHONE# _____ □ cell □ home

EMAIL_____ □*YES, I would like to be added to your email list for updates about Child Study Center. I understand my information will be kept confidential, and I can unsubscribe at any time.*

EMERGENCY CONTACT (NEAREST RELATIVE NOT LIVING WITH YOU):

NAME_____RELATIONSHIP_____PHONE# _____

HOUSEHOLD MEMBERS

NAME_____AGE_____RELATIONSHIP_____CSC CLIENT □YES □NO
NAME_____AGE_____RELATIONSHIP_____CSC CLIENT □YES □NO
NAME_____AGE_____RELATIONSHIP_____CSC CLIENT □YES □NO
NAME_____AGE_____RELATIONSHIP_____CSC CLIENT □YES □NO
NAME_____AGE_____RELATIONSHIP_____CSC CLIENT □YES □NO

PLEASE CIRCLE FAMILY INCOME *(FOR UNITED WAY PURPOSES ONLY)*

$0-$20,750 $20,751-$34,599 $34,600-$55,349 $55,350 and over

Patient's Initials ___

I. IN THE SPACE BELOW, PLEASE LIST THE MAIN CONCERNS THAT YOU HAVE FOR YOUR CHILD (Please describe why you are applying, and what questions you have about your child)

1. Please check the following reasons you are applying to the Child Study Center:
   - □For an evaluation of my child's attention or hyperactivity problems.
   - □For an evaluation of my child's learning problems (including dyslexia, math, writing).
   - □For an evaluation of my child's developmental delays (language, social skills, motor skills).
   - □For an evaluation to determine if my child has autism.
   - □To talk to a doctor about my child's current medications.
   - □For a second opinion of my child's diagnosis, which is _____
   - □I am interested in the ABA behavioral program for children ages 3-8 who have autism.
   - □I am interested in the Jane Justin special education school for children ages 3-12 years old.
   - □I am interested in the Behavior Disorders Clinic (BDC) for children with Autism
   - □Other reasons (describe): _____
2. Please mark if your child has: □Tried to hurt/kill himself/herself □ Tried to hurt/kill others □Had extreme temper tantrums or meltdowns
3. When did your child's problems begin? _____
4. What is your child's medical or psychiatric diagnosis? _____
5. Does your child receive special education? □YES □NO If yes, what is the classification?
   □Autism □Intellectual disability □PPCD □Speech impairment □Specific learning disability
   □Other health impaired □Emotional disturbance □Behavioral disturbance □Traumatic brain injury
6. Is your child currently receiving any of the following?
   □ECI □ABA Therapy □Speech Therapy □Physical Therapy □Occupational Therapy
   □Counseling □504 Accommodations □Attends private school
7. Do you want your child to see a specific doctor? If yes, which doctor? _____

II. PREGNANCY AND BIRTH HISTORY

1. Was this child adopted? □YES □NO If yes, how old when you took him/her home? _____
2. Length of pregnancy: _____ weeks Birth weight: _____lbs. ___ozs.
3. Mother's age at time of pregnancy: ___ Father's age at time of pregnancy ___
4. Problems with pregnancy **[please check (✓), if applicable]**:
   a. Bleeding/spotting..... ___
   b. Diabetic state in pregnancy (sugar in urine)..... ___
   c. High blood pressure..... ___
   d. Alcohol used..... ___
   e. Tobacco used..... ___
   f. Toxic exposures..... ___If checked (✓), explain _____
   g. Infections..... ___If checked (✓), explain _____
   h. Prescribed medications..... ___If checked (✓), explain _____
   i. Other drugs used..... ___If checked (✓), explain _____
   j. Other problems _____
5. Labor: □Induced □Spontaneous How long was the labor? ____ hours
6. Delivery: □Vaginal □Forceps used □Vacuum assisted □Caesarian
7. If Caesarean, why? □Scheduled □Failure to progress □Emergency _____
8. At what hospital was the baby born?_____
9. The baby stayed in the: □Regular nursery □NICU Discharged at____days of life

IN THE BOX BELOW, PLEASE EXPLAIN ANY OTHER IMPORTANT INFORMATION ABOUT YOUR CHILD'S BIRTH:

III. HEALTH/MEDICAL HISTORY

1. Who is your child's doctor? Doctor's Name_____
2. Does your child see a neurologist? □YES □NO If yes, name_____
3. Does your child see a psychiatrist? □YES □NO If yes, name _____
4. Does your child see a counselor? □YES □NO If yes, name _____
5. Does your child currently take medications (prescription/non-prescription) on a regular basis? □YES □NO
   If yes, which medications? _____
6. What other medications has your child previously taken? _____
7. Has your child ever had a psychiatric hospitalization? □YES □NO If yes, describe _____
8. Are there other medical problems? □YES □NO If yes, describe _____
9. Has your child had any serious injuries, especially with loss of consciousness? □YES □NO
   If yes, describe _____

Patient's Initials___

IV. IN THE BOX BELOW, EXPLAIN ANY OTHER IMPORTANT MEDICAL HISTORY OF YOUR CHILD, INCLUDING ANY HISTORY OF MEDICAL TESTS THAT HAVE BEEN PREVIOUSLY COMPLETED:

V. FAMILY HISTORY

1. HISTORY OF BIOLOGICAL MOTHER
   Education: □Did Not Graduate □GED □High School □Some college □Associate's □Bachelor's □Advanced
   Mother's Occupation: _____
   Please indicate if the child's biological mother had/has a history of:
   □Speech Problems □Learning Problems □Dyslexia □Attention Problems □Depression □Anxiety □Bipolar Disorder

2. HISTORY OF BIOLOGICAL FATHER
   Education: □Did not graduate □GED □High School □Some College □Associate's □Bachelor's □Advanced
   Father's Occupation: _____
   Please indicate if the child's biological father had/has a history of:
   □Speech Problems □Learning Problems □Dyslexia □Attention Problems □Depression □Anxiety □Bipolar Disorder

3. PARENTS' MARITAL STATUS/VISITATION
   Child's parents are: ___Never married ___Separated ___Divorced ___Married to each other ___
   If separated or divorced, who has primary custody? _____
   How often does the child see the non-custodial parent? __Regularly __Sometimes___

4. CHILD'S CURRENT LIVING SITUATION
   Who is the primary caretaker?_____

5. HISTORY OF BIOLOGICAL SIBLINGS
   Do any biological siblings have learning, speech, behavior, or other problems? □YES □NO
   If yes, describe _____

6. FAMILY HISTORY Mark (✓) if anyone on child's mother's OR father's side of the family has a history of:

___Learning disabilities/Dyslexia	___Attention Deficit Hyperactivity (ADHD)
___Slow learners	___Intellectual disability
___Speech/language disorders	___Autism/Asperger's/PDD-NOS
___Seizures	___Alcoholism
___Drug abuse	___Anxiety/extreme worrying
___Depression	___Bipolar Disorder (Manic-Depression)
___Schizophrenia	___Intermarriage between relatives
___Genetic syndromes	___Neurological problems

Patient's Initials___

VI. SCHOOL INFORMATION

School:_____School District: _____Grade:_____ Repeated Grades: _____

VII. SOCIAL HISTORY

1. Are you concerned about your child's ability to make friends and get along with others?
   ___Yes ___No If yes, explain: _____
2. Does your child have a best friend? □Yes □No
3. Does your child have good eye contact with others? □Yes □No
4. Does your child show interest in other children? □Yes □No

_____ _____ _____

Parent/Guardian Signature Relationship to Child Date

Assessment Scale – Parent Informant

Today

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?

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

D3 NICHQ Vanderbilt Assessment Scale—PARENT Informant, continued

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 elses 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: _____

SCHOOL QUESTIONNAIRE
To be completed by your child's current teachers

PLEASE COMPLETE IN BLACK INK

CHILD'S NAME: _____ BIRTHDATE:_____/____/_____

SCHOOL: _____ GRADE:_____SCHOOL DISTRICT: _____

ADDRESS:_____CITY/STATE/ZIP: _____

SCHOOL PHONE NUMBER: _____/_____ DATE FORM FILLED OUT:_____/_____/_____

NAME OF PERSON COMPLETING FORM: _____

1. Is this child in a Special Education program?	☐YES ☐NO If yes, explain: _____
2. Does this child receive any interventions?	☐YES ☐NO If yes, explain: _____
3. Does this child receive any classroom modifications?	☐YES ☐NO If yes, explain: _____
4. Does this child have problems with handwriting?	☐YES ☐NO If yes, explain: _____
5. Does this child have problems copying from the board?	☐YES ☐NO If yes, explain: _____
6. Does this child have difficulties making friends?	☐YES ☐NO If yes, explain: _____
7. Does this child have problems making eye contact?	☐YES ☐NO If yes, explain: _____
8. Does this child have problems expressing his/her thoughts?	☐YES ☐NO If yes, explain: _____
9. In your opinion, is this child functioning at capacity?	☐YES ☐NO If yes, explain: _____
10. Have you discussed these problems with his/her parents?	☐YES ☐NO

PLEASE DESCRIBE WHAT CONCERNS YOU MOST ABOUT THIS STUDENT:

PLEASE COMPLETE THE NICHQ VANDERBILT ASSESSMENT SCALE ON THE FOLLOWING (2) PAGES.

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: ____/____/____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

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

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous 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 in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: ____/____/____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments: _____

Please return this form to: _____

Mailing address: _____

Fax number: _____

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 – 28: _____

Total number of questions scored 2 or 3 in questions 29 – 35: _____

Total number of questions scored 4 or 5 in questions 36 – 43: _____

Average Performance Score: _____

NICHQ
National Initiative for Children's Healthcare Quality

American Academy of Pediatrics

McNeil
Consumer & Specialty Pharmaceuticals

Authorization to Obtain and/or Release Protected Health Information ("PHI")

This form, if signed, will authorize Cook Children's Health Care System ("CCHCS") to obtain and/or release certain health information about the person named below. All items must be completed and the authorization signed and dated by an authorized person to be valid. I may refuse to sign this authorization and I understand that CCHCS may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

1. I authorize CCHCS *(Please check all that apply)*:
   - ❑ Medical Center ❑ Physician Name/Clinic Name: _____
   - ❑ Home Health; to obtain and/or release health information, as described below, from the medical record of:

   Patient's full name: _____ DOB: _____

2. The information specified below may be obtained from and/or released to:

   _____ _____
   Name of person/organization Phone number

   _____ _____
   Address, City, State, Zip Code Fax number

3. Patient information is needed for *(Please check all that apply)*:
   - ❑ Personal use/Patient access ❑ Military ❑ Social security/Disability
   - ❑ Marketing ❑ Insurance/Billing/Claims ❑ Education
   - ❑ Continuing medical care ❑ Legal purpose ❑ Other: _____

4. Must select one: ❑ I want OR ❑ I do not want the specified information to be released to include history, diagnosis and/or treatment for: Genetics, HIV/AIDS/testing, Communicable diseases, Drugs/Alcohol, Mental Health disease.

5. Information to be released and/or obtained *(Please check all that apply)*:

   Specify dates of service: _____
   - ❑ Hospitalization reports ❑ Consultation reports ❑ Discharge summary ❑ Face sheet
   - ❑ Operative reports ❑ Emergency room record ❑ X-ray images ❑ History and physical
   - ❑ Audio, PT, OT, Speech evaluations ❑ Laboratory reports ❑ Pathology reports ❑ Progress notes
   - ❑ Radiology reports ❑ Medical information/images for marketing or education
   - ❑ Speciality Clinic Notes ❑ Other: _____

   _____ _____ _____
   Approve verbal communication with Date of visit Initials

6. I understand and acknowledge the following statements: I may be asked to show proof that I have the authority to sign this authorization. I may be charged a fee for any copies of my medical records or my child's medical records in accordance with federal and state regulations. I have the right to revoke this authorization at any time. Revocation must be made in writing to: ***Cook Children's Health Care System, Health Information Management Department, 801 7th Avenue, Fort Worth, Texas 76104.*** My revocation will not apply to information that has already been disclosed in response to this authorization. After the above medical information is released, it may be re-released by the recipient and the information may no longer be protected by federal privacy laws or regulations.
   REVOCATION: Unless otherwise revoked in writing, this authorization is valid until the following specific date (optional): Month _____ Day _____, Year _____. For patients under the age of 18 at the time this authorization is signed, if no expiration date is indicated, this authorization is valid until the patient's 18th birthday. For patients who are 18 years of age or older at the time this authorization is signed, if no expiration date is indicated, this authorization will expire 2 years from the date this form is signed.

7. _____ _____ _____ _____
   Patient/Parent/Legally Authorized Representative Signature Patient/Parent/Legally Authorized Representative Printed Name Date Time

8. _____
   Relationship to patient

PRINT OR IMPRINT PATIENT INFORMATION

CookChildren's.

801 7th Avenue
Fort Worth, Texas 76104-2796

CSN _____

MRN _____