PATIENT'S NAME: ___________________________ MGH MRN: ___________________________
(Patient must be registered at MGH, which can be done by calling the Registration Center @ 866-211-6588)

DATE OF BIRTH: ___________________________ INSURANCE: ___________________________
(We are contracted with most insurances, however we are not contracted with CIGNA, Fallon, Network Health)

If patient is a child, please provide:
NAME OF PARENT(S): ___________________________
PARENT HOME TEL: ___________________________ PARENT WORK/CELL TEL: ___________________________
EMAIL ADDRESS TO CONFIRM RECEIPT OF REFERRAL: ___________________________

WHO RECOMMENDED THAT YOU CONTACT US? (Check all that apply)
☐ Parent/Self
☐ Pediatrician
☐ Psychologist/Psychiatrist: If yes, please provide name/institution: ___________________________
☐ Medical Doctor/Specialist: If yes, please provide name/institution: ___________________________

WHY ARE YOU SEEKING AN EVALUATION AT LEAP? (Briefly explain your concerns about your child’s mental/medical health, behavioral, or academic issues.)

---

**Does your child have a history of any of the following? (Check all that apply)**

| ☐ Prematurity/low birth weight | ☐ Delayed motor skills |
| ☐ Hydrocephalus | ☐ Cerebral Palsy |
| ☐ Epilepsy or Seizure Disorder | ☐ Delayed language skills |
| ☐ Early Intervention Services | ☐ Special Education Services |
| ☐ Other Chronic Medical Condition: | |
| ☐ Genetic/chromosomal condition: | |

---

**Has your child been diagnosed with or do you currently have concerns about any of the following conditions? (Check all that apply)**

| ☐ Attention Deficit Hyperactivity Disorder (including ADD) | ☐ Autism-Spectrum Disorders, including Pervasive Developmental Disorder & Asperger’s Disorder |
| ☐ Anxiety ~Obsessive-Compulsive Disorder ~Difficulties with separation | ☐ Aggressive or oppositional behaviors ~Post-traumatic Stress Disorder ~Specific fears or phobias |
| ☐ Depression or mood swings | ☐ Tics or Tourette’s Disorder |
| ☐ Social Difficulties | ☐ Learning Disabilities |
| ☐ Substance abuse | Reading_________ Math_________ |
Is your child seeing or has your child ever seen a psychiatrist, psychologist, or therapist?
Name and Phone Number of Provider: ____________________________________________
Briefly explain why and how long you have been working with this provider.

Has your child seen a neurologist or developmental pediatrician in the past?
Name and Phone Number of Provider: ____________________________________________
Briefly explain why and how long you have been working with this provider.

Is your child taking any prescription medications? If so, then please list names and dosages.

Is your child currently receiving any of the following services:

☐ Occupational/physical therapy
☐ Speech and Language Therapy
☐ Social Skills Training
☐ Applied Behavior Analysis (ABA) Therapy
☐ Special Education Services as part of an IEP or 504

Has your child had any previous testing:

☐ Academic Testing (through the school or another clinic)
  o If yes, please provide dates of testing:
  _______________________________________________________

☐ Neuropsychological/Psychological Testing
  o If yes, please provide dates of testing:
  _______________________________________________________

Learning and Emotional Assessment Program
Department of Psychiatry
151 Merrimac Street, 5th Floor
Boston, MA 02114