

PARENT QUESTIONNAIRE

A. General Information

Child's name: _____ Male Female

Name at birth if different from above: _____

Resident Address: _____ City/Town/Village: _____

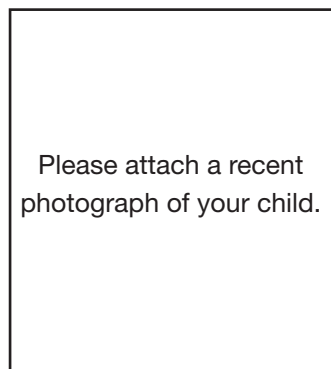
Province/Territory: _____ Postal code: _____

Child's date of birth (yy/mm/dd): _____ Age: _____

Provincial health care insurance number: _____

Alternate health care plan name: _____ Number: _____

Is the child a Registered or Treaty Indian? Yes No



Parents/Legal Guardians:

Name: _____

Address: Same as child; or:

No./street: _____

City: _____ Prov/Terr: _____ Postal Code: _____

Phone: (H) _____ (W) _____ (C) _____

Biological Adoptive Foster

Step-parent Grandparent

Name: _____

Address: Same as child; or:

No./street: _____

City: _____ Prov/Terr: _____ Postal Code: _____

Phone: (H) _____ (W) _____ (C) _____

Biological Adoptive Foster

Step-parent Grandparent

Language(s) spoken at home: 1. _____ 2. _____

If English is not spoken at home, indicate the name of an English-speaking contact person:

Phone: (H) _____ (W) _____ (C) _____

List everyone living in the home: _____

Child's guardianship status (if applicable): _____

Social worker/legal guardian (if applicable): _____

Address: _____ Phone: _____ Fax: _____

Who suggested this referral? _____

Family physician: _____ Paediatrician: _____

Please list your main concerns:

Do you have any specific questions you would like answered?

Current daycare/preschool/school: _____ Grade/level: _____

Contact name and title/role: _____ Phone: _____

List the preschools, daycare centres, and schools your child has attended. Use a separate sheet if necessary:

Name of program/school	Years attended	Grade/level	Problems noted	Special programs

Previous assessments:

	Date	Consultant or agency	Is your child currently involved?
Psychology			
Speech-language pathology			
Occupational/physiotherapy			
Audiology (hearing)			
Vision			
Other:			

PLEASE ATTACH ANY AVAILABLE REPORTS OF PREVIOUS ASSESSMENTS TO THIS QUESTIONNAIRE.

Are you aware of any assessments planned in the next six to twelve months? Yes No

If yes, when, where, and by whom? _____

B. Prenatal/Birth History

Total number of pregnancies: _____ Any miscarriage(s)/stillbirth(s)/abortion(s): _____

Duration of this pregnancy (weeks): _____

Did you have any of the following during this pregnancy?

Check all that apply:

- | | | |
|--------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Excessive vomiting | <input type="checkbox"/> Operation(s) | <input type="checkbox"/> Excessive vaginal bleeding |
| <input type="checkbox"/> Infection with fever or rash | <input type="checkbox"/> Injuries/accidents | <input type="checkbox"/> Other health problems: _____ |
| <input type="checkbox"/> Toxemia (high blood pressure) | <input type="checkbox"/> Unusual emotional stress | _____ |
| <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Prolonged hospitalization(s) | _____ |

During your pregnancy, did you:

Smoke cigarettes? No Less than 1/2 pack per day 1/2 to 1 pack per day
 More than 1 pack per day

Drink alcoholic beverages? No First three months only Throughout most of pregnancy

Amount each time (1 drink = 1 beer, 1 glass of wine, or 1 mixed drink):

1-2 drinks 3-5 drinks 6 drinks or more

Frequency: Once per week Two or more times per week

Use prescription or nonprescription medications? No Yes

Use any drugs (marijuana, cocaine, heroin, etc.)? No Yes

Name of birth hospital: _____ City/Province: _____

How long was labour? _____ hours Was labour: Spontaneous? Induced?

Type of anaesthetics: General Spinal Local None Other

Method of delivery: Spontaneous Assisted (forceps used) Vacuum extraction
 Vaginal Caesarean (elective) Caesarean (emergency)

Position of baby: Head first Breech Other

Were there any concerns about your baby (such as fetal distress) immediately before the birth?

No Yes Please explain: _____

Did your baby need any help to breathe right after birth?

No Yes Please explain: _____

What was your baby's birth weight? _____

How was your baby fed? Were there any feeding problems? _____

Did your baby have any of these problems at birth or during the first month of life? Check all that apply?

- | | | |
|-----------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Poor sucking | <input type="checkbox"/> Injured at birth | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Unusual rash | <input type="checkbox"/> Trouble breathing | <input type="checkbox"/> Was given medications |
| <input type="checkbox"/> Turned yellow | <input type="checkbox"/> Turned blue | <input type="checkbox"/> Infection (specify)_____ |
| <input type="checkbox"/> Received blood transfusion | <input type="checkbox"/> Kept in incubator (how long?_____) | <input type="checkbox"/> Seizures/convulsions |
| <input type="checkbox"/> Needed surgery | <input type="checkbox"/> Transferred to intensive care nursery | <input type="checkbox"/> Was very jittery |
| <input type="checkbox"/> Other problems: _____ | | |

C. Child's Developmental and Medical History

Early development: When (specify age in years and months, if possible) did your child first accomplish the following:

Age	Milestone	Age	Milestone	Age	Milestone
	Sat without help		Crawled		Walked alone for 10 to 15 steps
	Toilet trained (day)		Toilet trained (night)		Walked upstairs
	Rode a bike without training wheels		Used sentences		Used a spoon
	Spoke first words ("mama," "dada")		Rode a tricycle using pedals		Named 3 or more colours
	Ate independently		Counted from 1 to 10		Named 3 or more body parts
	Used fingers to feed		Put 2 or 3 words together		

When did you first become concerned about your child's development? _____

Do you have any concerns now? _____

Has your child lost any skills he or she used to be able to do? _____

Functional problems: Please check which, if any, of the following concerns you have:

- | | | |
|----------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Feeding difficulties | <input type="checkbox"/> Withdrawn/In own world | <input type="checkbox"/> Unusual/Odd mannerisms |
| <input type="checkbox"/> Avoiding eye contact | <input type="checkbox"/> Clumsy/Awkward/Poorly coordinated | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Limited food choices | <input type="checkbox"/> Recurrent stomach ache | <input type="checkbox"/> Unusual fears/Anxiety |
| <input type="checkbox"/> Social skill difficulties | <input type="checkbox"/> Resistance to change of routine | <input type="checkbox"/> Trouble falling asleep |
| <input type="checkbox"/> Soiling | <input type="checkbox"/> Night crying/Nightmares | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Shy with strangers | <input type="checkbox"/> Snoring | <input type="checkbox"/> Rocking/Head banging |
| <input type="checkbox"/> Recurrent headaches | <input type="checkbox"/> Hyperactive/
Impulsive | <input type="checkbox"/> Aggression toward self
or others |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Defiant/Negativistic | <input type="checkbox"/> Cruelty to animals |
| <input type="checkbox"/> Destructive to property | <input type="checkbox"/> Stealing | <input type="checkbox"/> Setting fires |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Inappropriate sexual behaviour | <input type="checkbox"/> Thumb-sucking/Nail-biting |
| <input type="checkbox"/> Frequent temper tantrums | <input type="checkbox"/> Resistance to going to school | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Trouble with police | | |

Discipline: When your child is misbehaving, what do you usually do?

Past health problems: Please give age of occurrence and details.

- | | | |
|---------------------------------------------|-----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Hearing problem | <input type="checkbox"/> Tics or muscle twitches |
| <input type="checkbox"/> Rash/Skin problems | <input type="checkbox"/> Eye problem | <input type="checkbox"/> Casts/Braces |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Recurrent infections | <input type="checkbox"/> Surgery (operations) |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Admissions to hospital |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other (specify): _____ |

Details: _____

List any long-term medication, special diets, or large doses of vitamins (taken for longer than two weeks at a time)?

Name/dose: _____	When: _____
Name/dose: _____	When: _____
Name/dose: _____	When: _____
Name/dose: _____	When: _____

Birth parent information/Family history:

Birth mother

Name: _____
Date of birth: _____ Age: _____
Present occupation: _____
Education (highest grade completed): _____
Any learning/behaviour/
emotional problems? _____
Any health problems? _____

Birth father

Name: _____
Date of Birth: _____ Age: _____
Present occupation: _____
Education (highest grade completed): _____
Any learning/behaviour/
emotional problems: _____
Any health problems? _____

Marital status: _____ Are the birth mother and father related? Yes No

Describe special circumstance (e.g., other parental relationships involved): _____

Siblings:

Full Name	Date of birth	Gender (M/F)	Grade	Relationship (full, step, half)	Health, learning or behaviour problems

Health conditions in the family:

Check conditions that apply and indicate relationship to your child.

Problem/Condition	Relationship to child	Problem/Condition	Relationship to child
ADHD		Migraine headaches	
Behaviour problems in childhood		Epilepsy	
Learning, reading problems		Autism spectrum disorder	
Speech problems		Thyroid problems	
Developmental delay		Depression	
Repeated a grade		Anxiety disorder	
Genetic syndrome/birth defect		Drinking problems	
Vision problems		Drug abuse	
Hearing problems		Other mental health issues	
Cerebral palsy		Other: _____	

Have there been any major events that may have been stressful to the family (e.g., moving home, physical/mental illness, death, separation/divorce, unemployment, legal or financial problem)?

Additional information that you feel may help us better understand your child (e.g., additional school history):

Name of person filling out this form: _____

Signature: _____ Date: _____