PARENT QUESTIONNAIRE

Reset Form

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

Please attach a recent photograph of your child.

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.

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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:

❑ Excessive vomiting ❑ Operation(s) ❑ Excessive vaginal bleeding

❑ Infection with fever or rash ❑ Injuries/accidents ❑ Other health problems:

❑ Toxemia (high blood pressure) ❑ Unusual emotional stress

❑ Convulsions/seizures ❑ Prolonged hospitalization(s)

During your pregnancy, did you:

Smoke cigarettes? ❑ No ❑ Less than ½ pack per day ❑ ½ 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:

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?

❑ Poor sucking ❑ Injured at birth ❑ Birth defects

❑ Unusual rash ❑ Trouble breathing ❑ Was given medications

❑ Turned yellow ❑ Turned blue ❑ Infection (specify)

❑ Received blood transfusion ❑ Kept in incubator (how long?) ❑ Seizures/convulsions

❑ Needed surgery ❑ Transferred to intensive care nursery ❑ Was very jittery

❑ 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:

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- ❑ Withdrawn/In own world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

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

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

- ❑ Ear infections
- ❑ Hearing problem
- ❑ Tics or muscle twitches
- ❑ Rash/Skin problems
- ❑ Eye problem
- ❑ Casts/Braces
- ❑ Head injury
- ❑ Recurrent infections
- ❑ Surgery (operations)
- ❑ Meningitis
- ❑ Allergies
- ❑ Admissions to hospital
- ❑ Seizures
- ❑ Asthma
- ❑ 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: