

## PARENT QUESTIONNAIRE

### A. General Information

Child's name: \_\_\_\_\_  Male  Female

Name at birth if different from above: \_\_\_\_\_

Resident Address: \_\_\_\_\_ City/Town/Village: \_\_\_\_\_

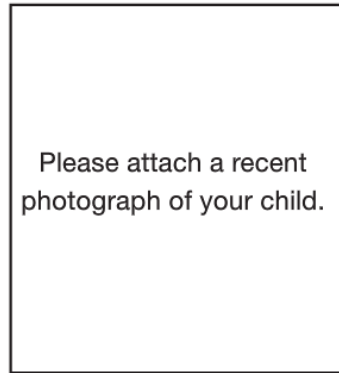
Province/Territory: \_\_\_\_\_ Postal code: \_\_\_\_\_

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:

- Excessive vomiting
- Infection with fever or rash
- Toxemia (high blood pressure)
- Convulsions/seizures
- Operation(s)
- Injuries/accidents
- Unusual emotional stress
- Prolonged hospitalization(s)
- Excessive vaginal bleeding
- Other health problems: \_\_\_\_\_

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: \_\_\_\_\_

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.

- |   |   |  |
|---|---|--|
| <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)?

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

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Name of person filling out this form: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_