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

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.

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: _____