PARENT QUESTIONNAIRE

A. General Information

Child's name: _____ Gender:

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? If yes, when, where, and by whom? Yes ❑ No ❑

B. Prenatal/Birth History

Duration of this pregnancy (weeks): _____

Did any of the following occur 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 this pregnancy, did the birthing person:

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 the baby (such as foetal distress) immediately before the birth?

❑ No ❑ Yes Please explain: _____

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

❑ No ❑ Yes Please explain: _____

What was the baby's birth weight? _____

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

_____

Did the 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 supplements (taken for longer than two weeks at a time)?

Name/dose: _____ When: _____

Name/dose: _____ When: _____

Name/dose: _____ When: _____

Name/dose: _____ When: _____

Biological parent information/Family history:

Biological mother

Name: _____

Date of birth: _____ Age: _____

Present occupation: _____

Education (highest grade completed): _____

Any learning/behaviour/
emotional problems? _____

Any health problems? _____

_____

Biological father

Name: _____

Date of Birth: _____ Age: _____

Present occupation: _____

Education (highest grade completed): _____

Any learning/behaviour/
emotional problems: _____

Any health problems? _____

_____

Are the biological mother and father related? ❑ Yes ❑ No

_____

_____

Siblings:

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

Health conditions in the family:

Check conditions that have been diagnosed in biological relatives.

	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: _____