Parent Questionnaire

A. General Information

Child's name ____

Please attach a recent photograph of your child and return it with this questionnaire to Dr.____________

Today's date ____________________________________

Child's date of birth ____________________________

❑ Male ❑ Female

Insurance Number ________________________________

Name of person(s) completing this form ____

Relationship to child ____

If you are not the legal guardian, who is? ____

Address ____________________________________ City ____________________

Province ____________________ Postal Code ____________ Telephone ( ) ____________

Who initiated this referral? Name ____

Occupation: ❑ family doctor ❑ paediatrician ❑ nurse

❑ teacher ❑ social worker ❑ other (specify)

Please list your main concerns:

1. ____

2. ____

3. ____

4. ____

Do you have any specific questions you would like answered?

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____

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____

Who is the child's usual doctor?____

Please list the physicians that have cared for your child in last three years:

Name ______________________ Regarding ______________________

Name ______________________ Regarding ______________________

Name ______________________ Regarding ______________________

Name ______________________ Regarding ______________________

Name of your child's current daycare/preschool/school:

______________________________________ Telephone (   ) ______________

Teacher's name ______________________________ Child's level grade ______________

Quality of parent/school relationship ______________________________________

Please list the preschools, daycare centres and schools your child has attended in the past, indicating the name, year, grade, problems noted and special programs:

1. ____

____

2. ____

____

3. ____

____

4. ____

____

Previous assessments:

❑ Psychology: ______________ When ______________ Where ______________

❑ Speech/Language Pathology: When ______________ Where ______________

❑ Occupational Therapy: ______________ When ______________ Where ______________

❑ Physiotherapy: ______________ When ______________ Where ______________

❑ Audiology: ______________ When ______________ Where ______________

❑ Vision: ______________ When ______________ Where ______________

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Is your child currently involved in any assessments/programs? ❑ Yes ❑ No

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? ____________________

Has your child received long-term medication, special diets or large doses of vitamins (taken for longer than two weeks at a time)? ❑ Yes ❑ No

Name ____________________ When ____________________

Name ____________________ When ____________________

Name ____________________ When ____________________

Name ____________________ When ____________________

B. Prenatal/Birth History

Total number of pregnancies ____________________ Any miscarriage(s)/still birth(s)/abortion(s) ____________________

Duration of this pregnancy (weeks) ____________________ Total weight gain during the pregnancy ____________________

Did you have any of the following during this pregnancy? If yes, please explain:

❑ Yes ❑ No Infection with fever or rash ____________________

❑ Yes ❑ No Toxaemia (high blood pressure) ____________________

❑ Yes ❑ No Convulsions/seizures ____________________

❑ Yes ❑ No Operation(s) ____________________

❑ Yes ❑ No Injuries/accidents ____________________

❑ Yes ❑ No Unusual emotional stress ____________________

❑ Yes ❑ No Other health problems ____________________

Excessive vaginal bleeding: ❑ Yes ❑ No

❑ 1st three months ❑ 2nd three months ❑ 3rd three months For how long? ____________________

❑ Yes ❑ No Hospitalization: If yes, why and for how long? ____________________

____

Were any of the following medications, drugs or substances used during pregnancy?

❑ Yes ❑ No ❑ Cigarettes: Less than ½ pack per day ❑ ½ to 1 pack per day

❑ More than 1 pack per day

❑ Yes ❑ No ❑ Alcoholic Beverages: First three months only ❑ Throughout most of pregnancy

Amount each time (1 drink -- 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

❑ Yes ❑ No Prescription/nonprescription medications: Name them. ____________________

____

❑ Yes ❑ No X-ray during pregnancy: ____________________

❑ Yes ❑ No Other drugs (marijuana, cocaine, heroin, etc.) ____________________

Child's birth place:

Name of hospital ____________________ City ____________________

How long was labour? Hours ____________________ ❑ Was labour spontaneous? ❑ Induced?

Type of anaesthetics: ❑None ❑ Spinal/Epidural ❑ Local

❑ General ❑ Other

Method of delivery: ❑ Spontaneous ❑ Assisted (forceps used) ❑ Vacuum extraction

❑ Vaginal ❑ Breech ❑ Other

❑ Caesarean (elective) ❑ Caesarean (emergency)

Birth weight of baby Mother's age at delivery

____

❑ Yes ❑ No Were there any concerns about the baby (such as fetal distress) immediately before the birth? Please explain.

____

❑ Yes ❑ No Did the baby require assistance to breathe right after birth? Please explain.

____

❑ Yes ❑ No Was your baby breast-fed? If yes, were there problems?

____

Were any of the following problems encountered at birth or during the first month of your baby's life?

- ❑ Born with cord around neck
- ❑ Cord presented first
- ❑ Poor sucking
- ❑ Injured at birth
- ❑ Unusual rash
- ❑ Trouble breathing
- ❑ Turned yellow
- ❑ Turned blue
- ❑ Received blood transfusion
- ❑ Kept in an incubator (how long)
- ❑ Needed surgery
- ❑ Transferred to Intensive Care Nursery
- ❑ Was very jittery
- ❑ Seizures/convulsions
- ❑ Was given medications
- ❑ Had birth defects
- ❑ Infection (specify)____

____

- ❑ Other Problems ____

____

____

____

C. Child's Developmental and Medical History

Early development: Approximately when (please specify age in years and months if known) did your child first accomplish the following:

AGE

_______Sat alone without support for five minutes

_______Enjoyed scribbling

_______Walked alone for 10-15 steps

_______Spoke first words with meaning

_______Rode a tricycle using pedals

_______Rode a bicycle without training wheels

_______Used a spoon

_______Used fingers to feed

AGE

_______Tied shoelaces

_______Toilet trained (day)

_______Toilet trained (night)

_______Walked upstairs

_______Put two or three words together

_______Used sentences

_______Named three or more colours

_______Counted from 1 to 10

Functional problems: Which problems occur for your child?

- ❑ Feeding difficulties
- ❑ Poor appetite
- ❑ Poor eating habits
- ❑ Constipation
- ❑ Recurrent stomachache
- ❑ Recurrent headache
- ❑ Trouble falling asleep
- ❑ Night crying/nightmares
- ❑ Bed wetting
- ❑ Soiling his or her pants
- ❑ Short attention span
- ❑ Aggressive behaviour
- ❑ Hurting himself or herself (hitting, biting)
- ❑ Defiant, negativistic
- ❑ Mood swings
- ❑ Breath-holding spells
- ❑ Frequent temper tantrums
- ❑ Thumb sucking/nail biting
- ❑ Resistance to going to school
- ❑ Withdrawn/in own world
- ❑ Avoiding eye contact
- ❑ Unusual/odd mannerisms
- ❑ Rocking/head banging
- ❑ Unusual fears
- ❑ Resistance to change of routine
- ❑ Overactive
- ❑ Underactive
- ❑ Miserable/tearful
- ❑ Shy with strangers
- ❑ Dependent behaviour
- ❑ Making embarrassing remarks
- ❑ Destructive
- ❑ Cruel to animals
- ❑ Stealing
- ❑ Setting fires
- ❑ Inappropriate sexual behaviour
- ❑ Trouble with police
- ❑ Other behaviours that worry you

Past health problems: (please give age of occurrence and details)

AGE AND DETAILS

❑ Ear infections ____________________

❑ Rash/skin problems ____________________

❑ Loss of consciousness ____________________

❑ Meningitis ____________________

❑ Seizures ____________________

❑ Hearing problem ____________________

❑ Eye problem ____________________

Past health problems: (please give age of occurrence and details) (continued)

AGE AND DETAILS

- ❑ Recurrent infections ______________________________
- ❑ Allergies ______________________________
- ❑ Asthma ______________________________
- ❑ Casts/braces ______________________________
- ❑ Surgery (operations) ______________________________
- ❑ Admissions to hospital ______________________________
- ❑ Other (specify) ______________________________

____

Discipline:

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

1. ______________________________
2. ______________________________
3. ______________________________

Parent information/family history:

Mother's name ______________ ❑ Biological ❑ Adoptive ❑ Foster ❑ Step-parent

Father's name ______________ ❑ Biological ❑ Adoptive ❑ Foster ❑ Step-parent

Marital Status: ______________ ❑ Married ❑ Separated ❑ Divorced ❑ Common-law

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

____

____

____

____

____

____

____

MOTHER

Home phone ( ) ______________________

Business phone ( ) ____________________

Occupation:

Present ______________________________

Previous _____________________________

Age _________________________________

FATHER

Home phone ( ) ______________________

Business phone ( ) ____________________

Occupation:

Present ______________________________

Previous _____________________________

Age _________________________________

Cultural Background:

(e.g. Canadian Caucasian, Canadian Native, European [specify], Asian [specify], and so on)

Mother: _________________________________

Father: _________________________________

Language(s) spoken at home

Mother: _________________________________

Father: _________________________________

Education:

Mother:

Highest grade completed ________________

Had learning problems ❑ Yes ❑ No

Repeated a grade ❑ Yes ❑ No

Attended special class ❑ Yes ❑ No

Years of post-secondary education __________

Father:

Highest grade completed ________________

Had learning problems ❑ Yes ❑ No

Repeated a grade ❑ Yes ❑ No

Attended special class ❑ Yes ❑ No

Years of post-secondary education __________

Health:

Mother:

Health problems (specify)

____

____

____

Emotional disorders (specify)

____

____

Father:

Health problems (specify)

____

____

____

Emotional disorders (specify)

____

____

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Siblings:

Please give name, age, sex, grade in school, relationship (e.g., full-, step-, or half-sibling) and indicate problems occurring for each of this child's siblings:

Name ____________________ age __________ ❑ male ______ ❑ female ______

grade ________ relationship: ❑ full ❑ step ❑ half Problems: ❑ health ❑ behaviour ❑ learning ______

Please describe ____

Name ____________________ age __________ ❑ male ______ ❑ female ______

grade ________ relationship: ❑ full ❑ step ❑ half Problems: ❑ health ❑ behaviour ❑ learning ______

Please describe ____

Name ____________________ age __________ ❑ male ______ ❑ female ______

grade ________ relationship: ❑ full ❑ step ❑ half Problems: ❑ health ❑ behaviour ❑ learning ______

Please describe ____

Name ____________________ age __________ ❑ male ______ ❑ female ______

grade ________ relationship: ❑ full ❑ step ❑ half Problems: ❑ health ❑ behaviour ❑ learning ______

Please describe ____

Health conditions in the family:

Please check as many items as apply and say how each person is related to your child.

RELATIONSHIP OF PERSON(S) TO CHILD

- ❑ Hyperactive/attention deficit ______________________________
- ❑ Genetic syndrome/birth defect ______________________________
- ❑ Learning, reading problem ______________________________
- ❑ Mental retardation ______________________________
- ❑ Speech problem ______________________________
- ❑ Developmental delay ______________________________
- ❑ Repeated a grade ______________________________
- ❑ Bed wetting ______________________________
- ❑ Hearing difficulties ______________________________
- ❑ Behavioural problem in childhood ______________________________

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Health conditions in the family:

Please check as many items as apply and say how each person is related to your child.

RELATIONSHIP OF PERSON(S) TO CHILD

- ❑ Visual problem ______________________________
- ❑ Nervous disorder ______________________________
- ❑ Cerebral Palsy ______________________________
- ❑ Migraine headache ______________________________
- ❑ Epilepsy ______________________________
- ❑ Thyroid problem ______________________________
- ❑ Depression ______________________________
- ❑ Drinking problem ______________________________
- ❑ Drug abuse ______________________________
- ❑ Physical/sexual abuse ______________________________
- ❑ Other problem(s) ______________________________

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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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