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?

______

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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

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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 ____________________

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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)

____

____

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____

____

____

MOTHER	**FATHER**
Home phone ( ) ______	Home phone ( ) ______
Business phone ( ) ______	Business phone ( ) ______

Occupation:

Present ______	Present ______
Previous ______	Previous ______
Age ______	Age ______

Cultural Background:

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

______	______

Language(s) spoken at home

______	______

Education:

Highest grade completed ______	Highest grade completed ______
Had learning problems ❑ Yes ❑ No	Had learning problems ❑ Yes ❑ No
Repeated a grade ❑ Yes ❑ No	Repeated a grade ❑ Yes ❑ No
Attended special class ❑ Yes ❑ No	Attended special class ❑ Yes ❑ No
Years of post-secondary education ______	Years of post-secondary education ______

Health:

Health problems (specify)	Health problems (specify)
______	______
______	______
______	______
Emotional disorders (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 ______________________________

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) ______________________________

____

____

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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