PARENT QUESTIONNAIRE

A. General Information

Child's name: ______________________ Nickname: __________

Name at birth if different from above: ______________________

Resident Address: ______________________ City: __________

Province/Territory: ______________________ Postal code: __________

Child's date of birth (dd/MMM/yyyy): __________ Age: ______ Gender at birth: ______

Provincial health care insurance number: __________ Gender identity: ______

Alternate health care plan name: __________ Number: __________

Does the child have First Nation Status? ❑ Yes ❑ No Band/Nation: __________

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.

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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

Duration of this pregnancy (weeks): ____________________

Tell us about any complications or health problems during this pregnancy

____

____

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):

❑ 1–3 drinks ❑ 4+ drinks

Frequency: ❑ Once or twice ❑ 2-6 days per week ❑ 7 days 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 ❑ Epidural ❑ Gas ❑ None ❑ Other

Method of delivery: ❑ Spontaneous ❑ Forceps ❑ Vacuum extraction

❑ Vaginal ❑ Caesarean (elective) ❑ Caesarean (emergency)

Position of baby: ❑ Head first ❑ Breech ❑ Other ____________________

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Were there any concerns about the baby (such as low heart rate or 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?

❑ Transferred to intensive care nursery
❑ Kept in incubator (how long? ____)
❑ Was very sleepy
❑ Trouble breathing
❑ Turned yellow
❑ Was very jittery
❑ Turned blue
❑ Received phototherapy
❑ Unusual rash
❑ Heart problem
❑ Was given medications
❑ Needed surgery
❑ Seizures/convulsions
❑ Had an infection ________
❑ Birth defects
❑ Received blood transfusion
❑ Withdrawal symptoms
❑ No poop in 48hrs
❑ Other problems: ____________________

C. Child's Developmental and Medical History

Early development: When (specify age in years and/or months, if possible) did your child first accomplish the following:

Age	Milestone	Age	Milestone	Age	Milestone
	Sat without help		Walked for 10-15 steps		Rode a tricycle
	Spoke first words		Named 3 + body parts		Spoke 2-3 word phrases
	Used fingers to feed		Ate with a spoon		Toilet trained (day)
	Smiled at you		Played peek-a-boo		Pointed to things
	Pretended with toys		Played with other children		Had a best friend

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? ____________________

Past health problems: Please give age of occurrence and details.

❑ Hearing problem	❑ Recurrent infections	❑ Recurrent stomachaches
❑ Vision problem	❑ Ear Infections	❑ Constipation
❑ Head injury	❑ Rash/skin problems	❑ Surgery (operations)
❑ Migraines/headaches	❑ 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: ________

Current job: ______________________________

School (highest grade completed): ____________

Any learning/behaviour/
emotional problems? ____________________

Any health problems? ____________________

____

Biological father

Name: ______________________________

Date of Birth: ____________ Age: ________

Current job: ______________________________

School (highest grade completed): ____________

Any learning/behaviour/
emotional problems: ____________________

Any health problems? ____________________

____

Are the biological mother and father related to each other (eg. cousins)? ❑ Yes ❑ No

Siblings:

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

Health conditions in other family members:

Check conditions that have been diagnosed in the child's 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: ______________________

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