elmtree clinic
NURTURING YOUNG MINDS

# Parent Questionnaire

We require this form to be completed *along with* a referral from a physician.

We do not do custody and access assessments or intervention.
We do not do parenting capacity assessments.

| | | |
|---|---|---|
| **Name of child:** | **DOB:** | **Birth Gender:** ❒M ❒F |
| Name of guardian completing this form: | | |
| Reasons for Referral: (e.g. specific concerns at home, preschool, daycare, or dayhome) | | |

## Child's Pre-Birth History

List any problems the mother had during pregnancy: (health, emotional struggles, stressors)

How far into the pregnancy when the mother found out she was pregnant? _____ weeks

This was the mother's ____ (#) pregnancy and ____ (#) child.

Length of pregnancy: ___weeks

Were any of the following used during pregnancy:

❒ **Cigarettes.** *Approximately _____ pack(s) per day.*

❒ **Prescription/non-prescription medication. _____**

_____

❒ **Alcoholic beverages.**

**Duration:** ❒ First month, ❒ First 3 months, ❒ Throughout the pregnancy

**Frequency:** ❒ none, ❒ Once per week, ❒ Two or more times per week

❒ **Marijuana**

❒ **Non-medicinal drugs.**

## Concerns During and After Birth

**Method of Delivery:** ❒Spontaneous ❒Induced ❒Assisted (forceps) ❒Head First ❒Breech ❒Vaginal ❒Caesarean

**Type of anesthetic:** ❒ none ❒ Put to sleep ❒ Other

Birth Weight of Child:

Were there any concerns about the baby just before or after birth? ❒ Yes ❒No

*(e.g. jaundice, low heart rate, lack of oxygen, infection*

If yes, please explain:

Was the baby cared for in the Neonatal Intensive Care Unit? ❒Yes ❒No

If yes, how long was the hospital stay? _____

## Child's Developmental History

During the first few years of life was your child:

| | Yes | No |
|---|---|---|
| Cuddly | ❒ | ❒ |
| A poor/restless sleeper | ❒ | ❒ |
| Easily calmed by holding/stroking | ❒ | ❒ |

**Overall mood:**

❒ "Easy"
❒ "Variable"
❒ "Difficult"
❒ _____

Early Development –At what age did your child first accomplish the following?

Sit up alone:

Crawl or bum scoot:

Walk alone 10-15 steps:

Use fingers to feed:

Use a spoon:

Wave/Point:

How much did your child babble? ❒ None ❒ A little ❒ A lot ❒ Constantly

At what age did your child say his/her first words?

Example words: _____

Put 2-3 words together? _____ Use sentences? _____

How many words is the child presently saying?

❒ 0-10 ❒ 10-50 ❒ >50 ❒ >100

If you cannot remember specific ages, were there concerns about your child's early development? ❒Yes ❒No

If yes, explain:

## Past or Present Health Problems

**Allergies:** ❒Yes ❒No

If yes, please describe:

**Feeding/eating problems:**

❒ Problems eating solid food ❒ Choking ❒ Swallowing problems.

❒ Picky eating ❒ Mealtime struggles ❒ Other loss of weight

**Sleep problems:**

❒ Trouble falling asleep ❒ Waking up during the night. ❒ Waking up too early.

❒ Sleep talking ❒ Sleepwalking. ❒ Night terrors.

❒ Teeth grinding ❒ Restless sleep ❒ Snoring

❒ Apnea (stopping breathing while sleeping)

❒ Other concerns about sleep: _____

**Toilet training problems:** ❒Yes ❒No

**Constipation:** ❒Yes ❒No ❒ Uncomfortable bowel movements ❒ Hard bowel movements

**Ear Infections** ❒Yes ❒No **Hearing Problems:** ❒Yes ❒No

**Eye or vision problems/glasses:** ❒Yes ❒No

**Frequent stomach aches:** ❒Yes ❒No **Frequently Sick:** ❒Yes ❒No

**Frequent headaches:** ❒Yes ❒No **Unexplained Fevers:** ❒Yes ❒No

**Has your child had any <u>serious illnesses</u> (seizures, meningitis), <u>serious injuries</u> (burns, falls, broken bones), or any <u>hospitalizations</u> or <u>operations</u>?** ❒ Yes ❒ No

If yes, please explain:

List any current or previous medications and special diets, herbal remedies, or vitamins:

## Family History

**Parent(s) or Guardian(s) descriptors:**

❒ Biological ❒ Adoptive ❒ Step- ❒ Foster ❒ Grandparent

**Family status:**

❒ Married ❒ Common-law ❒ Divorced ❒ Separated ❒ Widow/Widower

***If divorced or separated, both parents must sign the consent form agreeing to this referral.***

If parents are living apart, please describe the living arrangements/custody agreement:

| **Birth Parent History** | **Birth Mother** | **Birth Father** |
|---|---|---|
| **Name** | | |
| **Date of Birth:** (Day/Month/Year) | | |
| **Present Occupation:** | | |

**Health Conditions in the Birth Family**

Please check all items that apply and state how the person is related to this child.Indicate if on mother's or father's side of the family (for example: mother's aunt).

| | **Relationship to child** |
|---|---|
| ❒ Genetic Syndrome | _____ |
| ❒ Learning difficulties | _____ |
| ❒ Developmental Delay | _____ |
| ❒ Attention Deficit Hyperactivity Disorder (ADHD) | _____ |
| ❒ Tics or Tourette's disorder | _____ |
| ❒ Autism Spectrum Disorder (ASD) | _____ |
| ❒ Obsessive-Compulsive Disorder (OCD) | _____ |
| ❒ Anxiety | _____ |
| ❒ Speech problems | _____ |
| ❒ Hearing problems | _____ |
| ❒ Visual problems | _____ |
| ❒ Depression/Mood Challenges | _____ |
| ❒ Behavioral problems in childhood | _____ |
| ❒ Alcohol or substance use | _____ |
| ❒ Other | _____ |

| Siblings of Child | | |
|---|---|---|
| **Name, and Age** | **Relation (full/half/step)** | **Health/Behavior/Learning problems** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Present Circumstances |
|---|
| Please indicate any recent significant family events or problems that could be influencing your child's functioning. (e.g. At home, at work, housing, finances): |

Please attach all reports you have about your child.

Please watch the following videos on our website (www.elmtreeclinic.ca/videos)

1. "Introduction to the Clinic" series by Dr. Lorrain and Dr. Hapchyn
2. All eight of our NRF videos