ElmTree Clinic | 10010 162 St NW
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Parent Questionnaire

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

Guardians can phone us if they need to send this form separate from the referral.

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
Alberta Healthcare Number (PHN/ULI):		
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: ❒ Once per week ❒ Two or more times per week ❒ Daily

❒ **Marijuana:** ❒ Edible ❒ Vape ❒ Smoked

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

Frequency: ❒ Once per week ❒ Two or more times per week ❒ Daily

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

Can your child tell a complete story, with a beginning, a middle, and an end? ❒ Yes ❒ No

Your child… *(Mark box if applicable)*

❒ Enjoys Eye Contact ❒ Smiles to initiate interactions ❒ Seeks comfort from caregivers

❒ Has back and forth interactions with gesture or language ❒ Enjoys being with others

Past or Present Health Problems

Immunizations up to date?: ❒Yes ❒No

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: ❒ Hard poops ❒ Pooping twice or more daily (one year or older)
❒ Stool appears as small pellets ❒ Extra-large poops ❒ Straining and crying when pooping
❒ Bloody stool or bum ❒ Less than 1 poop per day ❒ Hiding when pooping
❒ Streaks of poop in underwear ❒ Belly pain ❒ Distended belly
❒ Decreased Appetite ❒ Diarrhea ❒ Reluctance to poop in toilet

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) relationship to child:

❒ 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:

Current Caregivers		
	1st Guardian	**2nd Guardian**
Name		
Preferred Pronouns		
Birthdate: (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/Language difficulties	_____
❒ Hearing difficulties	_____
❒ Depression/Mood Challenges	_____
❒ Behavioral challenges in childhood	_____
❒ Alcohol or substance use	_____
❒ Other	_____

	Siblings of Child		
Name	**DOB (YY/MM/DD)**	**Relation (full/half/step)**	**Health/Behavior/Learning problems**

Present Circumstances

Your Preferred Phone Number: _____

Your Email Address: _____

Please indicate any recent significant family events or problems that could be influencing your child's functioning. *(e.g. domestic concerns, work stress, housing issues, financial stressors):*

Services Accessed

Mark any services your child has received or been referred to.

- ☐ Speech and Language
- ☐ Audiology
- ☐ Stollery Sleep Clinic
- ☐ Neonatal Follow Up Clinic
- ☐ Glenrose IPAS
- ☐ Occupational Therapy
- ☐ Psychology
- ☐ Early Intervention
- ☐ Others: _____

Please include all reports with your child's referral.

Childcare *(If applicable)*

Name of Location: Director/Caregiver:

Address: Phone Number:

Children's Services Caseworker *(If applicable)*

Name: Phone Number:

Email Address:

Your child's caseworker MUST attend the first appointment.

Other Contacts or Services *(If applicable)*

Next Steps

1. Please bring all reports you have about your child.
2. Watch the following videos on our Youtube channel *https://www.youtube.com/@elmtreeclinic*
    a. Introduction to the Clinic video (for zoom appointments)
    b. The NRF playlist (for everyone)
    c. The Sleep Struggles playlist *(if applicable)*
    d. The Anxiety playlist *(if applicable)*
3. Consider registering for the NRF Starter Kit: https://nrfcare.org/starter-kit/
4. Consider watching the Circle of Security videos: https://www.circleofsecurityinternational.com/resources-for-parents/