





## Prenatal Period (Conception to Birth)

What was the mother's age at time of birth?

How many weeks occurred before the mother knew she was pregnant?

### Before knowing about the pregnancy did the mother's lifestyle contain any of the following:

The use of prescribed medication

No  Yes – What type of medication and for what reason?

The use of nicotine

No  Yes – If yes, how much was being used?

The use of alcohol

No  Yes – What type and how much was being used?

The use of illicit drugs

No  Yes – What type and how much was being used?

Experienced periods of high stress from relationships, work, community, finances or partner abuse

No  Yes – If yes, please explain

Was the birth of this child  Planned  Unplanned

Comment:

Was the birth of this child  Wanted by both Parents  Unwanted by either Parent  Unwanted, accepted by  mother  father

Comment:

What was the extended family's view of the pregnancy? Check all that apply.

Happy  Supportive  Concerned  Unsupportive  Other:

How did the mother feel physically during the pregnancy?

Did the mother experience any physical or emotional distress during the pregnancy?

No  Yes – Please comment of type of physical, or emotional distress



## Infancy (Birth to 2 years)

How would you describe the emotional climate of the home when the baby arrived?

Positive  Concerned  Negative  Comment

Who was the primary caregiver?

Mother  Father  Mother and Father  Other

Please list other caregivers

Mother  Father  Mother and Father  Other

Was the baby recalled to be a good eater, or fussy eater?

Good eater  Fussy Eater  Comment

Was the baby breast fed, or bottle fed?

Breast  Bottle  Comment

How Long?

Any reason why breast or bottle feeding was chosen?

What were the babies' early sleeping habits?

Good  Sleeper  Poor  Sleeper  Comments:

Was the baby "cuddly"?

No  Yes  Comments

Was the baby comfortable with expressing and receiving affection?

No  Yes  Comments

What was the baby's energy level?

Low  Average  High  Comments

Did the baby enjoy exploring the environment?

No  Yes  Comments

Was there anything that the baby appeared to find over-stimulating? (e.g. noise, clothing, people)

No  Yes  Comments

Do you think that your baby began to sit, stand, walk, talk unusually late or early? (if unsure give best number in months).

Low  Average  High  Comments:

Were there periods of high stress for the family in the first two years of life?

No  Yes - If yes, please describe the stress.

Was there any separation between child and mother during the first two years of life?

No  Yes. If yes, please describe why and how old the child was

Was there any separation between child and father during the first two years of life?

No  Yes. If yes, please describe why and how old the child was

When hurt, scared, or sick what was the child's typical reaction?

Calm down by their self  Cry  Yell in the spot where the situation happened  Seek their mother  Seek their father  Comments

Who was considered the primary parent for the child?

Mother  Father  Other

## Childhood (age 3 – 11)

### Toilet training

At what age did the use of diapers stop during the days?

At what age did the use of diapers stop during the night?

At what age did learning to tie shoes occur?

At what age did riding a bike occur?

Has your child ever been seriously ill? If so what was the illness, age of onset and treatment.

No  Yes  Comments

Any sensitivity to certain foods?

No  Yes  Comments

Any allergies? If so, to what and how was it treated.

No  Yes  Comments

Has your child had any serious accidents or head injuries or seizures?

No  Yes  Comments

Describe temper tantrums.

Any difficulties with speech?

No  Yes  Comments

Any phobias? (Unusual fears?)

No  Yes  Comments

Any unresolved phobias (unusual fears) by age 10?

No  Yes  Comments

Any unusual motor or vocal sounds? (Tics?)

No  Yes  Comments

Please comment on the following areas associated with childhood temperament
Activity: Activity refers to the child's physical energy. Please comment
Regularity: Regularity, also known as Rhythmicity, refers to the level of predictability in a child's biological functions, such as waking, becoming tired, hunger, and bowel movement. Please comment
Initial reaction: Initial reaction is also known as Approach or Withdrawal. This refers to how the child responds (whether positively or negatively) to new people or environments. Please comment
Adaptability: Adaptability refers to how long it takes the child to adjust to change over time (as opposed to an initial reaction). Please comment
Intensity: Intensity refers to the energy level of a positive or negative response. Does the child react intensely to a situation, or does the child respond in a calm and quiet manner? Please comment
A more intense child may jump up and down screaming with excitement, whereas a mild mannered child may smile
Mood: Mood refers to the child's general tendency towards a happy or unhappy demeanor. Please comment
Distractibility: Distractibility refers to the child's tendency to be sidetracked by other things going on around them. Please comment
Persistence and attention span: Persistence and attention span refer to the child's length of time on a task and ability to stay with the task through frustrations. Please comment
Sensitivity: Sensitivity refers to how easily a child is disturbed by changes in the environment. This is also called sensory threshold or threshold of responsiveness. Is the child bothered by external stimuli like noises, textures, or lights, or does the child seem to ignore them. Please comment
How would you describe the mother and fathers parenting style?
<b>Mother</b> <input type="checkbox"/> Passive <input type="checkbox"/> Assertive <input type="checkbox"/> Demanding <input type="checkbox"/> Aggressive <input type="checkbox"/> Other:
<b>Father</b> <input type="checkbox"/> Passive <input type="checkbox"/> Assertive <input type="checkbox"/> Demanding <input type="checkbox"/> Aggressive <input type="checkbox"/> Other:
What was the child's reaction to discipline like?
<input type="checkbox"/> Accepting <input type="checkbox"/> Passive <input type="checkbox"/> Defiant <input type="checkbox"/> Aggressive Other
Any tendencies for the child to be excessively independent or dependent?
<input type="checkbox"/> Dependent <input type="checkbox"/> Independent <input type="checkbox"/> Mix



Did the family experience periods of high stress during the childhood period?		
<input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, what type of stress and what was the child's reaction to the stress		
Was there any disruption in the parental relationship by separation, or divorce?		
Was the child exposed to any form of domestic violence?		
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please comment:		
During childhood where any of these features present (Please check all that apply)		
<input type="checkbox"/> Excessive Clingy	<input type="checkbox"/> Periods of being unresponsive	<input type="checkbox"/> Inability to self-sooth
<input type="checkbox"/> Seeking comfort and then aggressive behaviour	<input type="checkbox"/> Inability to deal with stress/separation	
Was medical or clinical assistance provided to help development during childhood?		
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, who provided the assistance and was it effective		
Was medication prescribed to help development during childhood?		
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what type of medication and dose (starting with the first) and their response to the medication		
<b><u>TYPE</u></b>	<b><u>DOSE</u></b>	<b><u>REPONSE</u></b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Was any herbal or non-medical supplement used to help development during childhood?		
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what was the supplement and was it effective		

**Adolescence (12-18 years)** (Skip if child is currently younger - go to Family Section)

When did puberty start?

10 yrs  11 yrs  12 yr  13 yrs  14 yrs

What was the child's reaction to the physical changes of puberty?

Comments

Please rate these skills for your child during this period.

<u>Area</u>	<u>1(Very Poor)</u>	<u>2(Poor)</u>	<u>3(Adequate)</u>	<u>4(Well)</u>	<u>5 (Very Well)</u>
Could handle feelings of sadness	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Could handle feelings of anxiety	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Could handle feelings of anger	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Could handle being excited	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Could handle sexual feeling	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Ability to show impulse control	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Ability to develop friendships	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Ability to maintain friendships	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Ability to accept parental redirection	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Ability to pick a positive peer group	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Could hold his/her beliefs despite beliefs of friends	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

Does the child experience mood swings beyond what is considered normal in adolescence?.

No  Yes if yes please comment

Has there been any problem with getting to sleep at night?

No  Yes If yes, how long between going to bed and falling asleep

Have there been any problems with staying asleep at night?

No  Yes if yes, do they  sleep talk  sleep walk  have nightmares  snore  awake repetitively?  Comment

Have there been any problems with awaking early in the morning and not being able to get back to sleep?

No  Yes

Is the child still tired in the morning despite sleeping?

No  Yes

Has the child ever not required sleep and stayed up for more than 24 hours?

No  Yes If yes, please describe their behavior around that time

If yes, please describe their behavior around that time?

No  Yes If no, please comment?

Is there any concern about the child's weight?

No  Yes If yes, please comment on underweight, or overweight.

If female is birth control prescribed, or if male is he aware of and have access to condoms?

No  Yes  Comments

Has the child been sexually active?

No  Yes If yes, when did this start  I Don't Know

Sexual Abuser/Abuse or victim?

No  Yes If yes, when did this start  I Don't Know

Has the child been sexually mistreated?

No  Yes If yes, when did this start  I Don't Know

Has the child sexually mistreated someone?

No  Yes If yes, when did this start  I Don't Know

Has the child experimented with nicotine?

No  Yes If yes, when did this start and how much is used per day.

Has the child used alcohol, or drugs?

No  I Don't Know  Yes If yes when did this start, what has been tried and how much is believed to be used

Has the child shown behavior that has resulted in contact with the police?

No  Yes If yes, what was the behavior and what did the police do.

Has the child ever run away from home?

No  Yes If yes, what was the trigger, where did they go and how long were they gone.

Has the child demonstrated any unusual interests, or fascinations?															
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please comment:															
Has the child reported the experience of any unusual sight, sounds, or physical feelings?															
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please comment:															
Has the child demonstrated periods of being unable to describe, or report why they engaged in disruptive behaviour?															
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please comment:															
Has the child shown any obsessive tendencies with: (check all that apply)															
<input type="checkbox"/> Television <input type="checkbox"/> Video Games <input type="checkbox"/> Music <input type="checkbox"/> Internet <input type="checkbox"/> Sexual material <input type="checkbox"/> Obsessed about another person <input type="checkbox"/> Drugs <input type="checkbox"/> Violence Please comment:															
Has the child ever displayed any reckless behavior that concerns you?															
<input type="checkbox"/> No <input type="checkbox"/> Yes if yes, please comment:															
Has any special gifts or talents emerge for your child during this period?															
<input type="checkbox"/> No <input type="checkbox"/> Yes Please Comment:															
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Was there any disruption in the parental relationship by separation, or divorce?															
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how old was the child, what was their reaction and how was care provided for the child.															
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<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what was the supplement and was it effective.															

## Family

Who are the current people living in the house and the relationship to your child?

Does your child have any brothers or sisters?

How old?

How do they get along?

Biological Mother - How would you describe yourself? What is your level of education? Any specific difficulties in school or specific likes or dislikes?

Biological Father - How would you describe yourself? What is your level of Education?

Any specific difficulties in school or specific likes or dislikes?

**Step Parent** - How would you describe yourself? What is your level of education?

Any specific difficulties in school or specific likes or dislikes?

Any family history [any biological relatives] of medical or psychological difficulties? Please check all that apply.

Issue	Who	Any known or unsuccessful treatments
<input type="radio"/> Depression		
<input type="radio"/> Anxiety (Phobias, OCD, Social)		
<input type="radio"/> Bipolar Disorder		
<input type="radio"/> ADHD		
<input type="radio"/> Suicidal Thoughts/suicides		
<input type="radio"/> Homicidal Thoughts/Homicides committed		
<input type="radio"/> Alcohol Misuse		
<input type="radio"/> Drug Use		
<input type="radio"/> Developmental Disabilities		
<input type="radio"/> Learning Disabilities		
<input type="radio"/> Criminal Charges/Jail time		
<input type="radio"/> Personality Disorders		
<input type="radio"/> Any Social/Emotional Issues		
<input type="radio"/> Any Medical conditions – esp. diabetes, obesity, heart disease, cancer		
<input type="radio"/> Sexual problems		
<input type="radio"/> Financial problems		
<input type="radio"/> Problems with driving		
<input type="radio"/> History of sudden deaths		

Any other family issues viewed as important

Comment

## Educational

What was the earliest grade your child attended in school, including nursery school?  
How old was your child?

Nursery School    3 yrs Jr. Kindergarten    4 yrs Sr. Kindergarten    5 yrs Grade 1 - 6 yrs

How did the child react with the separation from home?

Positive    Negative    Comments

Have any academic concerns developed? If so what and when?

Reading    Spelling    Math    Writing    Comprehension    other

Identified in:  JK    SK Grade    1-2 Grade    3-4    Grade 5-6    Grade 7-8

Has your child had any behaviour problems at school? If so what and when did they start?

Physical    Verbal    Sexual    Other

Identified in:  JK    SK Grade    1-2 Grade    3-4    Grade 5-6    Grade 7-8

What does your child's report usually look like?

Above Average    Average    Below Average    Barely Passing    Failing

Does the client receive any form of special assistance at school or outside of school to help their learning?

Does the client have an Educational Ministry Identification or Individual Education Plan? If identified, what is the identification? If on an IEP what is the focus.

<input type="checkbox"/> No IEP	<input type="checkbox"/> Communicative Learning Disability	<input type="checkbox"/> Mild Intellect Impairment	<input type="checkbox"/> Developmental Disability
<input type="checkbox"/> Speech & Language	<input type="checkbox"/> Medical	<input type="checkbox"/> Behavioural	<input type="checkbox"/> Multiple

Please comment on focus of IEP:

What is their current school and grade?

Any current academic issues of importance?

Comments

Has the child vocalized goals regarding their education?

Comments

**Employment** (If not of age, Skip to Medical Section)

Has there been a success part-time job experience?

No  Yes  Comments

Has there been success full-time job experienced?

No  Yes  Comments

Are there certain skills that stand in the way of successful employment?

Reading  Spelling  Math  Writing  Comprehension  Social Skills  Problems with Authority

Are there specific employment goals that have been stated?

Comment

**Medical**

Has a recent physical exam been completed?

No  Yes  Comments

Has recent blood work been completed?

No  Yes  Comments

Have recent hearing and vision tests been completed?

Are glasses prescribed?  Yes  No

Vision: Yes (fine) No Uses or needs glasses

Hearing: Yes (fine) No Identified problems

Any known specific allergies to medications?

No  Yes  Comments  Comment

Any known illness at the time of completing this form?

No  Yes  Comments  Comment

Prescription medication at the time of completing this form.

**Type**

**Dose**

**Believed Effectiveness**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any over the counter medications taken at the time of completing this form.

**Type**

**Dose**

**Believed Effectiveness**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctors involved in providing care at the time of this consultation

Family Doctor:

Psychiatrist:

Pediatrician

Counselor:

Other

Who would you like information involved in your care released to?

Yes – Obtain Receive/Release Information sheet

No – Please explain why

Developmental History Completed by: \_\_\_\_\_

Date of Completion: \_\_\_\_\_

Please fax this document to our office (613)967-3998 prior to your first appointment.

Thank you for completing this information it will be use to provide context to any other interview, or assessment data that is generated to develop appropriate treatment plans.

Date received: \_\_\_\_\_