



File # : \_\_\_\_\_

Name : \_\_\_\_\_

First Name : \_\_\_\_\_

**PEDOPSYCHIATRIC CLINIC  
 PRE-EVALUATION QUESTIONNAIRE  
 PERSONAL INFORMATION**

**IDENTIFICATION**

Name: \_\_\_\_\_ Given name: \_\_\_\_\_ Age: \_\_\_\_\_

Place of birth: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ City-district: \_\_\_\_\_ Postal code: \_\_\_\_\_

Home tel. no.: \_\_\_\_\_ Father, mother work tel. no.: \_\_\_\_\_ Father, mother cell no. \_\_\_\_\_

Email address: \_\_\_\_\_

Medicare Card No.: \_\_\_\_\_ Exp. date: \_\_\_\_\_

Referred by: \_\_\_\_\_ Family doctor: \_\_\_\_\_

Name of CLSC: \_\_\_\_\_ Name of caregiver: \_\_\_\_\_

**EDUCATION HISTORY**

Attended school: \_\_\_\_\_ School Board: \_\_\_\_\_

Last completed year or current year: \_\_\_\_ Teacher's name: \_\_\_\_\_ Director: \_\_\_\_\_

Previous evaluations: \_\_\_\_\_

Name of recent schools, academic years:

1. \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

2. \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Difficulties at school in relation to:

- His studies? (reading, writing, mental calculation, concentration and attention)  
 \_\_\_\_\_
- His behaviour? (superactivity, aggressiveness, impulsivity, negativity)  
 \_\_\_\_\_
- His relationship with teacher? (obedience, discipline)  
 \_\_\_\_\_
- His relationship with classmates? (sharing, tolerance, shyness)  
 \_\_\_\_\_

**MEDICAL AND DEVELOPMENTAL HISTORY**

Birth: Colour: \_\_\_\_\_ Tonus: \_\_\_\_\_ Weight: \_\_\_\_\_ Appetite: \_\_\_\_\_

Sleeping/awakening rhythm: \_\_\_\_\_ APGAR: 1 \_\_\_\_\_ 5 \_\_\_\_\_ 10 min. \_\_\_\_\_

How old was you child when he: held his head \_\_\_\_\_ crawled \_\_\_\_\_ walked \_\_\_\_\_ ran \_\_\_\_\_ jumped \_\_\_\_\_

climbed without falling \_\_\_\_\_ stopped bed dampering \_\_\_\_\_ controlled his bowels \_\_\_\_\_ Bicycled with 3 or 2 wheels \_\_\_\_\_

said his first words \_\_\_\_\_ pointed with finger \_\_\_\_\_ acquired the language \_\_\_\_\_ played alone \_\_\_\_\_ made up stories \_\_\_\_\_

Describe your child's character: \_\_\_\_\_ Visual, auditive or motor \_\_\_\_\_



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**PERSONAL INFORMATION**

Name: _____
File #: _____

Attitude at home (sense of limits, order): _____
Sense of danger (cautiousness): _____
Sense of truthfulness or fantasy (making up stories): _____
Coordination: _____
Games and sports: _____
Particular events: _____

**MEDICAL HISTORY**

Actual weight: _____ Height: _____
When your child did have his last medical exam? _____
Results: _____
Name of doctor: _____
Enumerate below: Illnesses, accidents, surgeries (date, doctor, hospital, duration): _____

Hereditary illnesses (ex. Allergies, diabetes, etc.) : _____
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<b>ACTUAL MEDICATION:</b> _____
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<b>PROBLEM SUMMARY:</b> _____
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ALL ANSWERS ARE CONFIDENTIAL. A SUBSEQUENT EVALUATION CANNOT BE USED WITHOUT THE CONSULTING PRACTITIONER'S AUTHORIZATION AS A LEGAL EXPERTISE (SOCIAL, EDUCATIONAL, LEGAL), BUT WILL ALLOW TO ESTABLISH A HYPOTHETICAL DIAGNOSIS AND A TREATMENT PLAN.

SIGNATURE (PARENT/GUARDIAN): _____ DATE: _____
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