



File #: _____
 Name : _____
 First Name : _____

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

IDENTIFICATION OF PARENTS

MOTHER:

Maiden name: _____ Given name: _____ Age: _____
 Place of birth: _____
 Marital Status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Number of years _____
 Educational level: _____ Occupation: _____
 Medicare Card No.: _____ Exp. date: _____ Email: _____

FATHER:

Name: _____ Given name: _____ Age: _____
 Place of birth: _____
 Marital Status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Number of years _____
 Educational level: _____ Occupation: _____
 Medicare Card No.: _____ Exp. date: _____ Email: _____

SIBLINGS: Enumerate below the other children in the family, according to their birth rank, given name, age, educational level, living at home or not, their occupation.

1. _____
2. _____
3. _____
4. _____

AND OTHER PERSONS:

Common-law partner:

of the father: Full name: _____ Age: _____ No. of children: _____
 Occupation: _____ Marital status: _____
 Medicare Card No. _____ Exp. date: _____

of the mother: Full name: _____ Age: _____ No. of children: _____
 Occupation: _____ Marital status: _____
 Medicare Card No. _____ Exp. date: _____

MEDICAL HISTORY AND DEVELOPMENT

MOTHER: MEDICAL HISTORY

Period of infertility: _____ No. of years: _____ Treatment: _____
 Threats or spontaneous abortions: _____ Months: _____
 Pregnancy: Morning sickness: _____ Vomiting: _____ Premature contractions: _____
 Hemorrhages: _____ Duration: _____ Treatment: _____ Medication: _____ Alcohol: _____
 Tobacco: _____ Weight gain: _____ Hypertension: _____ Swelling: _____
 Weeks of pregnancy: _____ Eclampsia: _____
 Labor: Natural: _____ Induced: _____ Caesarean: _____



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FAMILY INFORMATION

Name: _____

File #: _____

MOTHER: MEDICAL HISTORY (CONTINUED)

GLYCEMIC HISTORY:

Hypoglycemia: _____ Previous stoutness: _____ Actual weight: _____

Gestational diabetes: _____ 1st pregnancy: _____ 2nd pregnancy: _____ Others: _____

History of diabetes: Mother: _____ Father: _____

THYROID History:

Goiter: _____ Hyperthyroidism: _____

History: Mother: _____ Father: _____

Actual weight: _____ Waist circumference: _____

FATHER: MEDICAL HISTORY

Obesity: _____ Stoutness: _____ Smoking: _____

Individual diabetes: _____ Familial: _____

Actual weight: _____ Waist circumference: _____

INFLUENCES OF THE CHILD/ADOLESCENT ON THE FAMILY:

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: _____

