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 _____

Name: _____

File #: _____

PERSONAL INFORMATION

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.) : _____

ACTUAL MEDICATION: _____

PROBLEM SUMMARY: _____

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: _____

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: _____

Name: _____

File #: _____

FAMILY INFORMATION

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: _____