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For office use only: Date received: ____________________

BACKGROUND QUESTIONNAIRE

Date:	Person completing this questionnaire:

I. Identifying Information

Child's name:	Age:	D.O.B.:

Sex: ☐ Male ☐ Female ☐ Other	Race: ☐ Caucasian ☐ Hispanic ☐ Black ☐ Asian ☐ Indigenous ☐ Other
Home address: House/Unit Number: __________________________ Street: ____ City: ____ Province: ______________________________________ Postal code: ___________________________________ Home Phone: ___________________________________	Parents' marital status: ☐ Single ☐ Living together ☐ Married ☐ Separated ☐ Divorced ☐ Other If divorced, who has primary custody?___________ (Please attach proof of primary caregiver or custodial parent/legal guardian of child) With whom does the child reside? ☐ Mother ☐ Both (alternates homes) ☐ Father ☐ Other: _______________
Parent/Guardian: Name: ______________________________________ Age: ____ Work Phone: _______________________________ Cell: _______________________________________ Email:______________________________________ Where can messages can be left?	Parent/Guardian: Name: ___________________________________ Age: _____________________________________ Work Phone: ______________________________ Cell: _____________________________________ Email: ___________________________________ Where messages can be left?
Occupation:	Occupation:
Employer:	Employer:

Please list any other children in the family:

Name:	Sex:	Age:	Any diagnoses or other concerns?

Family Physician: Pediatrician:

II. Referral Source

How did you find out about our services?

What are your major concerns about your child at this time?

When were the above concerns first noticed?

III. Medical History

Does your child have any medical conditions or psychological diagnoses? ☐ Yes ☐ No

If YES, please describe:

Is your child taking any medications? ☐ Yes ☐ No If YES, please list: Medication Dose Prescribed for: Date started:	
Has your child…… had any major surgeries? ☐ Yes ☐ No ever been hospitalized? ☐ Yes ☐ No had any serious injuries? ☐ Yes ☐ No had seizures? ☐ Yes ☐ No	
If YES to any of the above please describe:	
Are your child's immunizations up to date? ☐ Yes ☐ No	
Does your child have any allergies? ☐ Yes ☐ No If YES, please list:	
Has your child had their hearing tested? ☐ Yes ☐ No Date tested: ______________________________	Results: ___________________________
Has your child had their vision tested? ☐ Yes ☐ No Date tested: ______________________________	Results: ___________________________

IV. Educational Information

Name of school:	Grade:
School Address:	Telephone:
Teacher's name:	
Does your child have an Individual Program Plan (IPP)? ☐ Yes ☐ No	
Does your child have a Special Education code? ☐ Yes ☐ No	If YES, code:

What days and times does your child attend school?
Does your child receive any interventions, therapies or other services at school? ☐Yes ☐No If YES, please list:
Do you have concerns about your child's academic progress? ☐Yes ☐No
Is your child having difficulty in any subject areas?☐ Yes ☐No If YES, which ones?

V. Family History

Please indicate with a check mark if any of the following apply:

	Child's Mother	Child's Father	Child's Brother	Child's Sister
Hyperactivity				
Distractibility				
Speech problems				
Dyslexia				
Trouble in school				
Trouble with reading				
Trouble with math				
Trouble with writing				
Held back in school				
Depression				
Anxiety				
Other mental illness				
Medical condition				
Drinking problem				
Drug problem				
Other (specify)				

What is the primary language spoken in your home? ____

VI. Pregnancy and Birth History

Did you take any medications or drugs during this pregnancy? ☐ Yes ☐No IF YES, what?
Did you drink alcohol during this pregnancy? ☐Yes ☐ No If YES, amount and frequency:

Did you use tobacco during your pregnancy? ☐ Yes ☐ No

If YES, amount and frequency:

Did you experience any problems during your pregnancy or birth with this child? ☐ Yes ☐ No

If YES, please describe:

Was your child born prematurely? ☐ Yes ☐ No

If YES, please explain:

Child's birth weight:

Did your child experience any difficulties during or after birth? ☐ Yes ☐ No

If YES, please explain:

VII. Developmental History

At what age did/was the child…? Sit up without assistance_________________

Crawl _____________________________ Walk unassisted _________________________

Bladder trained (day) ________________ Bladder trained (night) ___________________

Bowel trained _______________________ Say their first words ___________________

Use short phrases ___________________ Use sentences ___________________________

Did you have any concerns about your child's early development? ☐ Yes ☐ No

If YES, what were they?

VIII. Additional Information

Does your child participate in any extracurricular activities (e.g. clubs, organized sports)? If so, what days and times?
What are your child's strengths?
What are your child's weaknesses?
What does your child like to do in their downtime (i.e. favorite activities, toys, games, etc.)?
Is there anything else that you feel we should know about your child?

IX. Current Treatments

Is your child currently receiving services elsewhere? If so, with whom?
What type of services is your child receiving (e.g. psychology, speech therapy, OT, PT)?
What days and times does your child receive these services?

*Please select the 'Submit' button once complete. If you are having issues with submitting, download this form and email the completed form to **info@kidsetc.ca.**

In addition, if you have any of the following, please email copies to the above email:

- Proof of Primary caregiver or custodial parent/legal guardian of child
- Psychological
- Speech (SLP)
- Occupational therapy (OT)
- Physiotherapy (PT)
- School reports

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