Dan Kehoe, C.Psych.
Psychologist

CONFIDENTIAL PARENT INFORMATION FORM

I appreciate your support in completing this information form as it provides me with information that I require to best understand your child/adolescent. Once you complete the form, move your cursor to the top of the page and tap the arrow icon to save the file to your computer or tap the print icon to bring a copy to our first session.

Client's Name: Today's Date:

Date of Birth: Age: Male: Female:

School: Grade:

Home Address: Postal Code:

Name of person who referred you to this service:

FAMILY INFORMATION

Father's name: Age: Education:

Father's occupation: Tel:(hm) (wk) (c)

Mother's name: Age: Education:

Mother's occupation: Tel:(hm) (wk) (c)

E-mail Addresses:

Stepparent's name: Age: Education:

Language(s) spoken at home:

Marital status of parents:

If parents are separated or divorced, how old was the child when the separation occurred?

Other children (name) Sex Age In home? School/behaviour/health problems

Do any siblings have any significant academic/social/emotional or behavioural difficulties?

Did parents or other relatives experience any difficulties similar to those the child is experiencing, or other significant issues?

PRESENTING PROBLEM

Briefly describe what you are most concerned about your child/adolescent that led you to request this referral:

List any specific questions you would like answered by this evaluation/consultation:

Pregnancy

Duration:

Prenatal issues (e.g., toxemia, bleeding, high risk?)

Smoking or alcohol consumption?

Medications taken:

Delivery:

Type of labour: Spontaneous Induced Duration (hrs)

Type of delivery: Normal Breech Caesarean

Complications:

Birth Weight:

Post-delivery: Jaundice Cyanosis (turned blue) Incubator

Infancy

Breast or bottle fed?

Feeding Problems?

Sleeping Problems?

Did the child enjoy being held?

Was the child easy to soothe/calm?

Was the child social/interested in other people?

Did the child make eye contact?

MEDICAL HISTORY

Name of child/adolescent's Physician:

Do you have additional insurance coverage other than OHIP?

Has the child/adolescent experienced any serious illness, head injury, surgery, or accident(s)?

- ☐ 1. No
- ☐ 2. Yes, illness
- ☐ 3. Yes, surgery
- ☐ 4. Yes, accident
- ☐ 5. Other (specify)

Eyesight: Most recent exam: Results:

Describe any visual problem:

Hearing: Most recent exam: Results:

Describe any hearing problem:

Any history of ear infections? If so, has he/she had more than 6 ear infections?

Has child been considered hyperactive?

Has he/she a short attention span?

Has he/she had many school absences due to illness?

Has he/she any allergies?

Is the child/adolescent on any medication? Type & dosage:

Did your child have problems with any of the following?

- 1. Sleeping
- 2. Eating
- 3. Wetting
- 4. Soiling
- 5. Frequent physical complaints

If yes to any of the above, please provide further details:

EARLY DEVELOPMENTAL HISTORY

Activity Level - How active has your child been from an early age?

Distractibility - How well did your child pay attention?

ApproachlWithdrawal- How well did your child respond to new things (places, people, food,etc.)?

Intensity - Whether happy or unhappy, how aware are others of your child's feelings?

Mood - What was your child's basic mood in his/her early years?

Regularity - How predictable were your child's patterns of sleep, appetite, etc.?

How would you describe your child/adolescent's language development (e.g. 1st words, talking in sentences, vocabulary, etc.) during early childhood?

- 1. Advanced in comparison with other children
- 2. Average in comparison with other children
- 3. Slow in comparison with other children
- 4. Tended to express needs nonverbally
- 5. Not sure

Comments:

How would you describe your child/adolescent's motor development and skill acquisition (e.g. toilet training, running, jumping, throwing a ball, catching, cutting with scissors, etc.) during early childhood?

- 1. Advanced in comparison with other children
- 2. Average in comparison with other children
- 3. Slow in comparison with other children
- 4. Not sure

Comments:

How would you describe your child/adolescent's social development (e.g., development of friendships, relationships with peers, relationships with adults etc.)?

- 1. Advanced in comparison with other children
- 2. Average in comparison with other children
- 3. Slow in comparison with other children
- 4. Not sure

Comments:

How would you describe your child/adolescent's cognitive development (e.g., counting, knowledge of the alphabet, doing puzzles, understanding concepts etc.) during early childhood?

- 1. Advanced in comparison with other children
- 2. Average in comparison with other children
- 3. Slow in comparison with other children
- 4. Not sure

Comments:

SCHOOL HISTORY

What is your child/adolescent's current grade level?

How many schools has your child/adolescent attended since Junior Kindergarten?

Any grade repetitions? If so, which one(s)

Any special education class placement(s)?

Any remedial/special education assistance?

Has your child/adolescent been formally identified as an exceptional learner through the Identification, Placement, Review Committee process? If so, which classification

Does your child/adolescent have an Individual Education Program (IEP)?

Which of the following describe your child/adolescent's current attitude toward school:

- 1. Enjoys school
- 2. Feels neutral about school
- 3. Complains about going to school
- 4. Is afraid to go to school
- 5. Tries to avoid going to school

- ☐ 6. Usually gets along with teachers
- ☐ 7. Usually gets along with peers
- ☐ 8. Usually has problems with teachers
- ☐ 9. Usually has problems with peers

Which of the following describe your child/adolescent's current weaknesses in school. Please identify all weaknesses by clicking the box and please only mark those that apply:

- ☐ 1. Concentration
- ☐ 2. Organization
- ☐ 3. Papers and Reports
- ☐ 4. Handwriting
- ☐ 5. Written Expression
- ☐ 6. Memorizing
- ☐ 7. Getting assignments done on time
- ☐ 8. Being careful and checking work
- ☐ 9. Vocabulary and verbal expression
- ☐ 10. Understanding concepts
- ☐ 11. Behaving appropriately
- ☐ 12. Sounding out words
- ☐ 13. Reading speed
- ☐ 14. Reading comprehension
- ☐ 15. Spelling
- ☐ 16. Working hard and not giving up
- ☐ 17. Controlling impulses
- ☐ 18. Controlling emotions
- ☐ 19. Planning ability
- ☐ 20. Processing speed
- ☐ 21. Following directions
- ☐ 23. Arithmetic
- ☐ 24. Other

Briefly describe performance and concerns in each grade category:

Kindergarten:

Primary:

Intermediate:

High School:

Has your child/adolescent been assessed by school psychological, special education or other consultants? If so, give name, school district, and approximate date:

Has your child been seen for assessment or therapy by any outside consultant (psychiatric, psychological, speech and language, occupational therapy, remedial etc.)? Give name(s) and date:

Has your child experienced any significant behavioural problems at school? Please describe:

Does your child have difficulty paying attention/sitting still at school?

Does your child have friends at school?

Does your child see friends from school outside of school hours?

Is your child invited to social events by other children (e.q, birthday parties)?

Has your child ever been suspended from school? If so, please state reasons and approximate dates:

Has your child ever been in trouble with the law? Please describe:

ADDITIONAL INFORMATION

What are your child/adolescent's strengths or weaknesses? (Hobbies, sports, games, school subjects, social activities, personality characteristics, interests, talents).

Does your child have behavioural challenges at home? If so, what types of problems?

What have you found to be the most effective ways of helping your child/adolescent?

Is there any other information that may be important for me to know?

Thank you for this valuable information.