

Waypoint Centre for Mental Health Care

Family, Child, and Youth Mental Health Program Parent/Caregiver Questionnaire

Instructions

FAX COMPLETED FORM AND ANY ACCOMPANYING DOCUMENTATION TO:

**Waypoint Central Intake by fax to 705-549-1812 or by email to
centralintake@waypointcentre.ca**

Please complete this form to the best of your ability, include the following items with this questionnaire if possible:

- a. A copy of the Custody agreement for your child, if applicable
- b. Signed Release of Information Form
- c. A copy of the most recent report card
- d. Copies of occupational therapy, physiotherapy or speech therapy reports, psychological reports, psychiatric reports and school testing reports (or arrange for your family doctor to forward these if he/she has copies)

Date: _____

FOR WAYPOINT USE ONLY	Date Received:		Account #:	
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Client/Patient Information				
Name of Person Completing Form:				
Name of Child/Youth (Last name, first name):				
DOB (dd/mm/yyyy):		Preferred Name:		
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Trans (male to female) <input type="checkbox"/> Trans (female to male) <input type="checkbox"/> Two Spirit <input type="checkbox"/> Other (please specify):				
Preferred Pronoun(s):				
Health Card Number:			Version Code:	
Address:				
City:			Postal Code:	
Primary Telephone #:			Alternate Phone #:	
Who initiated this referral?				
Parent/Guardian/Caregiver Name:				
Address:				
City:			Postal Code:	
Primary Telephone #:			Alternate Phone #:	
Parent/Guardian Email Address:				
Interpreter required? <input type="checkbox"/> Language:				
Pharmacy:			Drug Allergy:	
Any other Physicians involved (i.e., Paediatrician)?			Issues Addressed:	

Please describe the main concerns and behaviours which worry you:



Child's Strengths: (Comment on talents, interests, skills, involvement in sports/clubs/or other activities, positive connections within the family, relatives, friends, and the community)

Main Stresses For The Child: (Have there been any major events, now or in the past, which may have been stressful to family, i.e., relocating, physical/mental illness or death, family breakdown, unemployment, violence, legal/financial problems (please identify)

Responding To Distress: (When your child is distressed, how do you, the parent/caregiver, respond)

Managing Behaviour: (When your child is misbehaving, how do you, the parent/caregiver, respond)

Traumatic Events: (Are you aware of any traumatic events that may have affected the child)

Do you have any questions you want answered?

1. _____
2. _____
3. _____

List other agencies ever involved with your child and years of involvement. Please provide note if available.

Custody status if applicable:

- Joint Other: _____
- Sole Custody Case Manager: _____
- Temp care agreement



Medical

Family Doctor: _____ Tel #: _____

Current medications, Special diets, vitamins, herbal supplements: (any over the counter) *attach list

Name and Dose	Response	Date Started / Discontinued	

Are you aware of any other assessments planned in the next 6 months? Yes No
(if yes provide the following)

When: _____ Where: _____ By Whom: _____

Child's Past Health Problems

	Age:		Age:	Other (Specify):	Age:
<input type="checkbox"/> Rash/Skin Problems		<input type="checkbox"/> Ear Infection(s)			
<input type="checkbox"/> Seizures		<input type="checkbox"/> Surgeries			
<input type="checkbox"/> Recurrent Infection(s)		<input type="checkbox"/> Meningitis			
<input type="checkbox"/> Head Injury					

Prenatal and Birth History and Early Development

Pregnancy Duration: _____ weeks. Was a doctor seen regularly: Yes No

Birth Weight: _____ Lbs _____ Ounces Was baby in an incubator after birth: Yes No

Any Complications?

Delivery/Early Months:

Any Fetal Distress Prior to Birth: (explain) _____ Other Health Problems: (explain) _____

Were any of the following taken or used: Alcoholic Beverages Cigarettes Drugs/Illicit Substances

Prescription/non-prescription medication during pregnancy: Yes No

Medication Names: _____



Childs First Year of Life: Check all that apply (generally describing)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Curious and inquisitive | <input type="checkbox"/> Fussy, cranky | <input type="checkbox"/> Enjoyed cuddling | <input type="checkbox"/> Poor Eating |
| <input type="checkbox"/> Stiffened when held | <input type="checkbox"/> Difficult to soothe | <input type="checkbox"/> Cried a lot | <input type="checkbox"/> Poor Sleep |
| <input type="checkbox"/> Easily startled/frightened | | <input type="checkbox"/> Happy | <input type="checkbox"/> Sound/Interested |

Any problems encountered during the first few months of life: (explain)

Child's Developmental Milestones:

As best as you can remember, at what age child reached the following milestones:

Sat up:		First Steps:	
Rolling:		First Words:	
Toilet Trained:			

Are immunizations up to date: (provide copy of record) Yes No

Eye Contact: Yes No Sharing: Yes No

Preschool and Early Years:

Did your child attend Day Care/Pre-School: Yes No

Did the child have difficulty with other children:
Did the child show unusual reactions to change in plans/routines:

Current School:

Does your child enjoy school?
Does your child get along with teachers?
Does your child get along with classmates?
Are there any school subjects they find especially difficult?



Past and Current Community Supports and Assessments:

Occupational Therapy (OT)	
Physiotherapy (PT)	
Speech Language Therapy (SLP)	
Psychoeducational Assessment	
Community resources, etc.	
Audiology/Hearing	

Schools Attended	Year(s)	Grade(s)	Noted Strengths or Problems	Special Program(s)

Family History:

	Parent 1		Parent 2	
	<input type="checkbox"/> Biological	<input type="checkbox"/> Step <input type="checkbox"/> Foster	<input type="checkbox"/> Biological	<input type="checkbox"/> Step <input type="checkbox"/> Foster
	<input type="checkbox"/> Adoptive	<input type="checkbox"/> Other:	<input type="checkbox"/> Adoptive	<input type="checkbox"/> Other:
Name (Surname, First Name):		Age:		Age:
Mailing Address, including postal code:				
Home Tel #:		Work Tel #:		Work Tel #:
Occupation:				
Language(s) Spoken:		Marital Status:		Marital Status:
	Current Partner:		Current Partner:	
Had Learning Problems:				
Attended Special Classes:				
Emotional problems during school years (specify):				
Any mental health concerns or substance abuse (specify):				



Siblings: Please list all biological and step-siblings

Name:		Age:	Grade:	Gender:
Relationship:		Problems:		
Name:		Age:	Grade:	Gender:
Relationship:		Problems:		
Name:		Age:	Grade:	Gender:
Relationship:		Problems:		
Name:		Age:	Grade:	Gender:
Relationship:		Problems:		

Biological Family Health Conditions: Check all that apply and identify the affected person's relationship to child.

Condition	Relationship to Patient
<input type="checkbox"/> Attention Deficit Hyperactive Disorder	
<input type="checkbox"/> Genetic Syndrome/Birth Defect	
<input type="checkbox"/> Learning/Reading Problem(s)	
<input type="checkbox"/> Childhood Behavioural Problems	
<input type="checkbox"/> Speech/Hearing Difficulties	
<input type="checkbox"/> Physical/Sexual Abuse	
<input type="checkbox"/> Emotional Problems (specify):	
<input type="checkbox"/> Other Problems (specify):	
<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Thyroid Problem(s)	
<input type="checkbox"/> Alcohol Problem(s)	
<input type="checkbox"/> Drug Abuse	
<input type="checkbox"/> Repeated a grade	
<input type="checkbox"/> Migraine Headaches	

