NEW BRIDGES
Child & Adolescent Psychological Services
25 Imperial Street Suite 210
Toronto, ON. M5P-1B9

Parent Intake Form

Name of Child/Adolescent: ____________________ Child's Date of Birth: ____________________

Date Completed: ____________________________ Age of Child: _________________________

Child's grade in school: ______________________ Gender: ____male ____ female

Name of person completing form: ________________

Relationship to Child/Adolescent: _________________

Languages spoken at home:__________________________

Purpose of this questionnaire
The purpose of this questionnaire is to obtain a comprehensive picture of your child's background. Please complete these questions as fully and accurately as you can. The questionnaire is long and detailed. If you require additional space to answer any questions, please use the reverse side of the sheet.

All information provided will be held in strict confidence.

Home address (including postal code):____

____

Is this your preferred mailing address?: yes_____ no_____ (if no, fill out alternate address below)

Alternate address:____

____

Phone Number(s): ____

E-mail address:____

Emergency contact person & phone number:____

Reason for Referral:

____
____
____
____

Other issues for which you would like help for your child:

____
____
____

Child’s Strengths:

____
____
____
____
____

Child’s Weaknesses:

____
____
____
____

In your opinion, what are the major causes of your child’s difficulties?

____
____
____
____

Do both parents agree on the nature and causes of your child’s problems? Yes___ No ____

Were there any particular stresses (past or present) which led, or contributed, to the current problem?

____
____
____
____

Has your child had direct contact with any social agency, psychologist, clinic or private agency?
Yes _____ No _____

If yes, please list

Dates of Service	Name of Professional	Type of Service

Pregnancy, Labor, Delivery

Health problems or significant stressors (if any) of mother during pregnancy with patient (i.e., bleeding, toxemia, measles, seizures, major accidents, etc.):

____

____

Length of Pregnancy ____

Any illness with fever and/or rash during pregnancy? ________________

Any drug or alchohol use? Yes No

If yes, indicate amount: ____

Did you smoke during pregnancy? Yes No

If yes, indicate amount:____

Labour – spontaneous or induced? _______________ Vaginal or C-section?______________

Describe any complications of birth: ____

____

Anesthesia during labour? Yes No

Baby's weight: ___________________________

Was baby born head first or feet first? __________________________

Was the cord wrapped around the baby's neck? ________________________________

Was mother awake when the baby was born? ________________________________

Did the baby breathe spontaneously right after birth? Yes No

If no, describe difficulty ____

Any other difficulties in labour and/or delivery? _____________________________________

Age of mother at delivery _____ Age of second parent at delivery _______

Was there any trouble with baby's first week of life, e.g., yellow color of skin (jaundice) or illness with fever? ____

____

If jaundiced, did baby require phototherapy (bilirubin lights) ? Yes No

Exchange transfusions? Yes No

Age of baby at time of hospital discharge (newborn period) ______________________________

Were there any problems during the first month baby was at home?

____

____

____

Medical History

Has your child ever had a serious illness? Yes No

If so, what? ________________________ When? __________________________

Has your child ever been hospitalized? Yes No

If so, why? ____

When? ____________________________ How long? _______________________

Has your child ever had any major operations? Yes No

If so, what? __________________________ When? _________________________

Does your child have asthma or allergies? Yes No

If so, what? ____

Has your child ever had a strep infection? Yes No When? ___________________

Has your child had any head injuries? Yes No

If so, what happened? __________________________ When? ___________________

Has your child had any loss of consciousness, not associated with a head injury (e.g., blackout)?

Yes No

Does your child have abdominal pains or vomiting? Yes No

If so, when does this occur? ____

How often does your child have headaches? ____

How are these treated? ____

Have the headaches ever been accompanied by vomiting? Yes No

Does your child have any difficulties related to eating? Yes No

If so, please describe: ____

Does your child have any difficulties related to sleeping? Yes No

If so, please describe:____

Does your child have any difficulties related to their vision? Yes No

If so, please describe:____

Does your child have any difficulties related to their hearing? Yes No

If so, please describe: ____

Has there been a history of frequent ear infections? Yes No

How often? ______________________________ When? ______________________

Do any medical illnesses run in your family? Yes No

If so, please indicate the following below:

Relationship to child (e.g., parent, sibling, grandparent, etc.)	Type of Illness	Treatment

In addition to prescribed medications, record in the next set of boxes any herbal remedies or vitamins that your child may be taking or has used in the past

Name of medication and dosage	Prescribed by	Date started	Discontinued	comments

Developmental History

Motor Milestones

Age sat alone: _______ Age crawled: ________ Age walked without holding on: _____________

Please rate your child's motor development compared to siblings and/or friends by checking box:

	Advanced	Average	Slow	Awkward
Running				
Skipping				
Climbing				
Bike riding				
Self-Help (e.g., dressing, brushing teeth, etc.)				
Throwing/Catching a ball				

When did your child develop a clear hand preference? __________ Right Left

Language

Age spoke first words: __________ Age used two to three words: __________

Does your child have any speech problems (stuttering, difficult to understand)? Yes No

If so, please describe: ____

Has your child ever required speech therapy? Yes No

If so, please describe: ____

Drooling past age 1 ½ years? Yes No

Difficulty sucking as an infant? Yes No

Difficulty chewing? Yes No

Please rate your child's ability to:

	Advanced	Average	Slow
Learn to name colours	_______	_______	_______
Recite the alphabet	_______	_______	_______
Count to ten	_______	_______	_______
Toileting	_______	_______	_______

Age trained for urine: _______ Age trained for bowels: _______

Bed wetting? Yes No

If yes, Age started _______ How often? _______ Age controlled: _______

Does/did your child have accidents during the day? Yes No How often? _______

Does/did your child have soiling? Yes No How often? _______

Behaviour

Does your child get along well with other children? Yes No

Does your child get along well with brothers/sisters? Yes No

Does your child have friends? Yes No

Does your child keep friends? Yes No

Does your child get along well with adults? Yes No

Shy	Yes	No	Tics/twitching	Yes	No
Immature	Yes	No	Average Intelligence	Yes	No
Well Behaved	Yes	No	Hyperactive	Yes	No
Stubborn	Yes	No	Clumsy	Yes	No
Impulsive	Yes	No	Poor handwriting	Yes	No
Temper tantrum	Yes	No	Head banging	Yes	No
Sleep problems	Yes	No	Rocking	Yes	No
Nightmares	Yes	No	Toe walking	Yes	No
Falling spells	Yes	No	Hard to comfort	Yes	No
Thumb sucking	Yes	No	Nail biting	Yes	No
Intentionally hurts self	Yes	No	Refusal to speak	Yes	No

Resists physical contact or touching	Yes	No
Repetitive/stereotyped movements (i.e. hand-flapping)	Yes	No
Difficulty staying in one activity for a reasonable length of time?	Yes	No
Does your child seem to have trouble reading social cues? (i.e. knowing when others are angry, understanding humour?)	Yes	No
Does your child have any difficulty making friends?	Yes	No
Does your child have any difficulty maintaining friendships?	Yes	No

Family History

Please list ALL family members names under parents. Please include step/adoptive relatives.
Check the names of children listed below currently living at home (indicate if adopted/fostered).

First **name** of each member	Age	Educational Level	Occupation	Health	School or behaviour problems	Living with child?

Current Family Situation

Language spoken at home: _______________

Parents are: married common law single parent divorced separated widowed

Custody arrangements (if applicable): _______________________________________

Previous marriages/cohabitation: ______________________________________

With which family member(s) does the child spend most time? _______________________

With which family member(s) does the child get along best? _______________________

Are there any significant conflicts between child and parent(s)? Yes No

If so, what? ____

Do parents agree on how to discipline the child? Yes No

Who disciplines the child and how? ____

____

How does the child respond to discipline? ____

____

Are the child's problems frequently the source of parental arguments? Yes No

Are there significant marital conflicts? Yes No

Family Psychological History

Please indicate any family members that have been diagnosed with any of the following:

Learning Disability: ____

ADD/ADHD: ____

Developmental Delay: ____

Behaviour Problems: ____

Anxiety Disorder: ____

Depression: ____

Bipolar Disorder: ____

Psychotic Disorder: ____

Substance Abuse: ____

Other (please specify): ____

Educational History

Current School: ____________________________ Present Grade: ______________

Private or Public School? ____________________________

Are there any school personnel involved with your child: _________________________

Has the school reported any problems with:

Reading	Yes	No
Writing	Yes	No
Spelling	Yes	No
Arithmetic	Yes	No
Social Adjustment	Yes	No
Behaviour (acting out with peers)	Yes	No
Behaviour (compliance problems)	Yes	No
Attention/Concentration	Yes	No

What grade did the school problems become noticeable? ______________

Any previous psychological tests? Yes No By whom? ______________

Any known learning disabilities? Yes No What kind? ______________

Who diagnosed the learning problems? ____

Any grades repeated? Yes No

Did child attend nursery school? Yes No

Did child attend junior kindergarten? Yes No

Were there any problems related to these experiences? Yes No

If so, please explain: ____

Any additional comments: ____

____

____

____

____

____

____

____

____

Please fill in your child's school history and any concerns reported in various grades:

GRADE	**NAME OF SCHOOL**	**CONCERNS**
Nursery		
JK		
SK		
Gr. 1		
Gr. 2		
Gr. 3		
Gr. 4		
Gr. 5		
Gr. 6		
Gr. 7		
Gr. 8		
Gr. 9		
Gr. 10		
Gr. 11		
Gr. 12		

How is your child doing now?

Please describe below whether or not your child's emotional difficulties impair his or her functioning (when compared to an average child of the same age) in the following areas:

School: Yes No

If yes, what is your child not able to do? ____

____

How often is this a problem (daily, weekly, monthly, etc.)? ______________________________

____

Friends: Yes No

If yes, what is your child not able to do? ____

____

How often is this a problem (daily, weekly, monthly, etc.)? ______________________________

____

Family Life: Yes No

If yes, what is your child not able to do? ____

____

How often is this a problem (daily, weekly, monthly, etc.)? ______________________________

____

Activities on Daily Living: Yes No

If yes, what is your child not able to do? ____

____

How often is this a problem (daily, weekly, monthly, etc.)? ______________________________

____

Any Other Impairments or Problems: Yes No

If yes, what is your child not able to do? ____

____

How often is this a problem (daily, weekly, monthly, etc.)? ______________________________

____