Avec nos mains, nos cœurs, et nos esprits ouverts
With our hands, hearts, and minds open

Intake Questionnaire

Programme d'évaluation en équipe interdisciplinaire
Team Interdisciplinary Developmental Evaluations (TIDEs) Program

1. General Information

Child's Name: ....

DOB:............. (Y) / .... (M) / ....(D) Child's age: ....

Name of person filling out form: ....

Relationship to child: ....

Address (where child lives): ....

....

Tel: .... (home) ....(work) .... (cell)

Email: ....

Who lives at home with the child?

Name	Age	Relationship to child (e.g., mother, sister etc.)

Please list any immediate family members living in another home:

....

Referring physician*: ....

(*please note that we require a medical consult from a primary physician (i.e. pediatrician or family MD)

Reason(s) for Consultations

Please list your main concerns that have led you to consult us[1]:

[1] In filling out this questionnaire, please type directly in the text boxes & expand as necessary

What are you hoping or expecting to gain from this consultation?

2. Birth & Medical History

Weeks of gestation (/40): ....

Pregnancy: Complications: ....

Assisted reproductions: ....

Consumption during pregnancy, including frequency & amounts (medications, alcohol, marijuana, etc.): ....

Delivery (please check): Vaginal .... C/S ....

Any complications during the delivery: ....

....

Please list any health problems your child has experienced or is currently experiencing (e.g., colic/feeding in first week of life, hospitalizations, surgeries):

Does s/he take any medications? (please circle) **Y** **N** If yes, please indicate the drug name & dose.

....

3. Developmental & Family History

Please indicate the approximate **age** at which your child reached the following milestones:

Milestone	**Age** e.g. 12 months		**Age**
Babbled		Smiled	
Pointed with index finer		Rolled over	
Said first word		Sat unassisted	
Produced short 2-3 word phrases		Crawled (on all 4s)	
Said full sentence (subject-verb-object)		Took first steps	

Please explain **when** you first became concerned about your child's development and/or learning (what specifically did you notice?) ....

....

Please list any medical, developmental, genetic, neurological or psychiatric disorders in the child's family history (e.g. ADD/ADHD, anxiety, ASD, learning disabilities, Tourette's syndrome, etc.) and how the person is related to the patient (e.g., brother, uncle, etc.).

Please indicate if your child has seen any of the following specialists[2]:

Specialist	**Where** (e.g. CLSC, rehab centre, private practice, school etc.)	**Type of service** (e.g., evaluation, treatment) **& time frame** (e.g., Oct-Dec 2016, ongoing)
Audiologist (hearing)		
Neurologist		
Occupational therapist		
Optometrist (vision)		
Physiotherapist		
Psychoeducator		
Psychologist/Neuropsychologist		
Psychiatrist		
Remedial educator/ orthopédagogue		
Social Worker		
Speech-language pathologist		

Has your child received a diagnosis related to development or learning? If yes, please explain.

....

Has your child received services from your local CLSC/CIUSSS? **Y N** If yes, please explain:

....

Has your family received services from a Centre Jeunesse? **Y N** If yes, please explain:

....

Please list services covered or partly covered by your private insurance company, if any (e.g.., occupational therapy) ....

[2] If you have report(s) from consultations with (a) specialist(s), please send us a copy by fax 514-934-3393 or by email www.centremeraki.com.

4. Child's Environment

i. **<u>0-5 years</u>** (*if your child is <u>school-age</u>, please disregard this section*)

If preschool-age, who cares for your child during the day? ....

Does your child attend daycare? If yes, please check: CPE .... Private daycare .... Preschool ....

Name of establishment: ....

How many days a week? ....

What is/are the language(s) of instruction at the centre?

....

How many hours of screen-time (weekdays and weekend) does your child view? Please describe type of screen-time (TV vs. educational apps)...

ii. **<u>6 years+</u>** (*if your child is <u>preschool-age</u>, please disregard this section*)

What school does your child attend? ....

His/her school is (check one) public .... private ....

His/her current grade at school: ....

Has your child repeated a grade or does he/she receive resource services at school? If yes, please explain: ....

....

iii. Please place an X next to any difficulties currently experienced by your school-age child:

.... Reading problems	.... Attention/concentration
.... Spelling/writing problems	.... Organization/planning
.... Mathematics difficulties	.... Impulsivity
.... Penmanship	.... Hyperactivity

iv. Please describe any other academic difficulties/issues

5. Social-Emotional Development & Behaviour

i) Place make an X next to any behaviour or problems that you child currently exhibits:

Frequent temper tantrums ....
Signs of anxiety ....
Oppositionality/Defiance ....
Aggression ....
Sleep difficulties ....
Regression in development ....
Peer relationship difficulties ....
Excessive activity ....
Signs of attachment problems ....
Feeding difficulties ....

ii) For school-age children:

Signs of poor self-esteem ....
Wets or soils self ....
Signs of depression ....
Odd/illogical beliefs or thoughts ....

Please describe any areas marked with an 'X' in more detail (i.e., when this behaviour occurs, how frequently it occurs, what triggers it, etc.):

Has your child been through a difficult and/or traumatic family situation (e.g. divorce, foster care/adoption, move)? If yes, please explain: ....

....

Any other family concerns? If yes, explain:...

....

....

6. Additional Information

What are your child's strengths? ....

....

What are your child's favourite activities? ....

....

Additional comments ....