MacEwan MEDICAL CLINIC

WELCOME TO MACEWAN MEDICAL CLINIC

To make the most of our initial meeting together, we ask you to complete the following questionnaire before your first appointment. This will provide us with the background and your concerns. This questionnaire gives us an overview of the past medical history of the patient and also some information about his/her family.

The questionnaire is from the Canadian Pediatric Society Since it is meant to cover from birth to 18 years of age; some of the questions may not be applicable to you.

Please print and fill out the form as completely as possible. Kindly, fax the filled form to (587) 392-5522, or drop off to the Clinic before the appointment, so that the pediatrician has time to review it in advance. If you have any questions, please call (403) 455-8382.

In addition, we also ask you to complete a SNAP questionnaire for student who are having learning difficulties as a screen for ADHD online at www.adhdratingscales.com. The instructions for completing this questionnaire online are at the end of this document.

Thank-you for taking the time to provide us with this information! We are looking forward to meeting your family!

Sincerely,

MacEwan Medical Clinic

(403)455-8382
macewanmedicalclinic@outlook.com
macewanmedical.com
12 – 16 MacEwan Drive NW Calgary, AB T3K 2P2

MacEwan MEDICAL CLINIC

PARENT QUESTIONNAIRE

Dear Parent/Guardian:
This questionnaire will provide us with important information regarding your child's birth, early medical history, education, and medical issues surrounding their medical condition, which will allow us to work with you more effectively. By completing this questionnaire prior to your appointment, you will be helping us to better understand your questions and the concerns which are affecting your child and your family. Based on the age of your child some of the questions /information requested may not be appropriate. Please answer

A. General Information

Child's name: _____ ❑ Male ❑ Female

Name at birth if different from above: _____

Resident Address: _____ City/Town/Village: _____

Province/Territory: _____ Postal code: _____

Child's date of birth (yy/mm/dd): _____ Age: _____

Provincial health care insurance number: _____

Is the child a Registered First Nations? ❑ Yes ❑ No

Please attach a recent photograph of your child. (OPTIONAL)

Parents/Legal Guardians:

Name: _____

Address: ❑ Same as child; or:

No./street: _____

City: _____ Prov/Terr: _____

Phone: (H) _____ (W) _____ (C) _____

❑ Biological ❑ Adoptive ❑ Foster

❑ Step-parent ❑ Grandparent

Name: _____

Address: ❑ Same as child; or:

No./street: _____

City: _____ Prov/Terr: _____

Phone: (H) _____ (W) _____ (C) _____

❑ Biological ❑ Adoptive ❑ Foster

❑ Step-parent ❑ Grandparent

Language(s) spoken at home: 1. _____ 2. _____

If English is not spoken at home, indicate the name of an English-speaking contact person:

_____

Phone: (H) _____ (W) _____ (C) _____

List everyone living in the home: _____

_____

Child's guardianship status (if applicable): _____

Social worker/legal guardian (if applicable): _____

Address: _____ Phone: _____ Fax: _____

Who suggested this referral? _____

Family physician: _____ Paediatrician: _____

Please list your main concerns:

_____

_____

Do you have any specific questions you would like answered?

_____

_____

Current daycare/preschool/school: _____ Grade/level: _____

Contact name and title/role: _____ Phone: _____

List the preschools, daycare centres, and schools your child has attended. Use a separate sheet if necessary:

Name of program/school	**Years attended**	**Grade/ level**	**Problems noted**	**Special programs**

Previous assessments:

	Date	**Consultant or agency**	**Is your child currently involved?**
Psychology			
Speech-language pathology			
Occupational/physiotherapy			
Audiology (hearing)			
Vision			
Other:			

PLEASE ATTACH ANY AVAILABLE REPORTS OF PREVIOUS ASSESSMENTS TO THIS QUESTIONNAIRE.

Are you aware of any assessments planned in the next six to twelve months? Yes ❑ No ❑

If yes, when, where, and by whom? _____

B. Prenatal/Birth History - **Please provide information for child being seen ONLY**

Total number of pregnancies: _____ Any miscarriage(s)/stillbirth(s)/abortion(s): _____

Duration of this pregnancy (weeks): _____

Did you have any of the following during this pregnancy?

Check all that apply:

❑ Excessive vomiting ❑ Operation(s) ❑ Excessive vaginal bleeding

❑ Infection with fever or rash ❑ Injuries/accidents ❑ Gestational Diabetes

❑ Toxemia (high blood pressure) ❑ Unusual emotional stress _____

❑ Convulsions/seizures ❑ Prolonged hospitalization(s) _____

During your pregnancy, did you:

Smoke cigarettes? ❑ No ❑ Less than ½ pack per day ❑ ½ to 1 pack per day

❑ More than 1 pack per day

Drink alcoholic beverages? ❑ No ❑ First three months only ❑ Throughout most of pregnancy

Amount each time (1 drink = 1 beer, 1 glass of wine, or 1 mixed drink):

❑ 1–2 drinks ❑ 3–5 drinks ❑ 6 drinks or more

Frequency: ❑ Once per week ❑ Two or more times per week

Use prescription or nonprescription medications? ❑ No ❑ Yes

Use any drugs (marijuana, cocaine, heroin, etc.)? ❑ No ❑ Yes

Name of birth hospital: _____ City/Province: _____

How long was labour? _____ hours Was labour: ❑ Spontaneous? ❑ Induced?

Birth Weight: _____kg

Type of anaesthetics: ❑ General ❑ Spinal ❑ Local ❑ None ❑ Other

Method of delivery: ❑ Spontaneous ❑ Assisted (forceps used) ❑ Vacuum extraction

❑ Vaginal ❑ Caesarean (elective) ❑ Caesarean (emergency)

Position of baby: ❑ Head first ❑ Breech ❑ Other

Were there any concerns about your baby (such as fetal distress) immediately before the birth?

❑ No ❑ Yes Please explain: _____

Did your baby need any help to breathe right after birth?

❑ No ❑ Yes Please explain: _____

_____

How was your baby fed? Were there any feeding problems?_____

_____

Did your baby have any of these problems at birth or during the first month of life? Check all that apply?

❑ Poor sucking ❑ Injured at birth ❑ Birth defects

❑ Unusual rash ❑ Trouble breathing ❑ Was given medications

❑ Turned yellow ❑ Turned blue ❑ Infection (specify)_____

❑ Received blood transfusion ❑ Kept in incubator (how long?_____) ❑ Seizures/convulsions

❑ Needed surgery ❑ Transferred to intensive care nursery ❑ Was very jittery

❑ Other problems:_____

C. Child's Developmental and Medical History

Early development: When (specify age in years and months, if possible) did your child first accomplish the following:

Age	Milestone	Age	Milestone	Age	Milestone
	Sat without help		Crawled		Walked alone for 10 to 15 steps
	Toilet trained (day)		Toilet trained (night)		Walked upstairs
	Rode a bike without training wheels		Used sentences		Used a spoon
	Spoke first words ("mama," "dada")		Rode a tricycle using pedals		Named 3 or more colours
	Ate independently		Counted from 1 to 10		Named 3 or more body parts
	Used fingers to feed		Put 2 or 3 words together		

When did you first become concerned about your child's development? _____

Do you have any concerns now?_____

Has your child lost any skills he or she used to be able to do? _____

Functional problems: Please check which, if any, of the following concerns you have:

- ❑ Feeding difficulties
- ❑ Avoiding eye contact
- ❑ Limited food choices
- ❑ Social skill difficulties
- ❑ Soiling
- ❑ Shy with strangers
- ❑ Recurrent headaches
- ❑ Short attention span
- ❑ Destructive to property
- ❑ Mood swings
- ❑ Frequent temper tantrums
- ❑ Trouble with police
- ❑ Withdrawn/In own world
- ❑ Clumsy/Awkward/Poorly coordinated
- ❑ Recurrent stomach ache
- ❑ Resistance to change of routine
- ❑ Night crying/Nightmares
- ❑ Snoring
- ❑ Hyperactive/ Impulsive
- ❑ Defiant/Negativistic
- ❑ Stealing
- ❑ Inappropriate sexual behaviour
- ❑ Resistance to going to school
- ❑ Unusual/Odd mannerisms
- ❑ Constipation/Diarrhea
- ❑ Unusual fears/Anxiety
- ❑ Trouble falling asleep
- ❑ Bedwetting
- ❑ Rocking/Head banging
- ❑ Aggression toward self or others
- ❑ Cruelty to animals
- ❑ Setting fires
- ❑ Thumb-sucking/Nail-biting
- ❑ Other: _____

Discipline: When your child is misbehaving, what do you usually do?

_____

Past health problems: Please give age of occurrence and details.

- ❑ Ear infections
- ❑ Hearing problem
- ❑ Tics or muscle twitches
- ❑ Rash/Skin problems
- ❑ Eye problem
- ❑ Casts/Braces
- ❑ Head injury
- ❑ Recurrent infections
- ❑ Surgery (operations)
- ❑ Meningitis
- ❑ Allergies
- ❑ Admissions to hospital
- ❑ Seizures
- ❑ Asthma
- ❑ Other (specify): _____

Details: _____

_____

List any long-term medication, special diets, or large doses of vitamins (taken for longer than two weeks at a time)?

Name/dose: _____ When: _____

Name/dose: _____ When: _____

Name/dose: _____ When: _____

Immunization up to date?
Yes ◯ No ◯

Allergies?
Yes ◯ No ◯

If yes please describe: _____

_____

Birth parent information/Family history:

Birth mother

Name: _____

Age: _____

Present occupation: _____

Education (highest grade completed): _____

Any learning/behaviour/

emotional problems? _____

Any health problems? _____

_____

Birth father

Name: _____

Age: _____

Present occupation: _____

Education (highest grade completed): _____

Any learning/behaviour/

emotional problems: _____

Any health problems? _____

_____

Marital status: _____ Are the birth mother and father related? ❑ Yes ❑ No

Describe special circumstance (e.g., other parental relationships involved): _____

_____

Siblings:

Full Name	Age	Gender (M/F)	Grade	Relationship (full, step, half)	Health, learning or behaviour problems

Health conditions in the family: (Ex. Mom, Dad, Brother, Grandma etc.)

Check conditions that apply and indicate relationship to your child.

	Problem/Condition	Relationship to child		Problem/Condition	Relationship to child
☐	ADHD		☐	Migraine headaches	
☐	Behaviour problems in childhood		☐	Epilepsy	
☐	Learning, reading problems		☐	Autism spectrum disorder	
☐	Speech problems		☐	Thyroid problems	
☐	Developmental delay		☐	Depression	
☐	Repeated a grade		☐	Anxiety disorder	
☐	Genetic syndrome/birth defect		☐	Drinking problems	
☐	Vision problems		☐	Drug abuse	
☐	Hearing problems		☐	Other mental health issues	
☐	Cerebral palsy		☐	Other:_____	

Have there been any major events that may have been stressful to the family (e.g., moving home, physical/mental illness, death, separation/divorce, unemployment, legal or financial problem)?

_____

_____

Additional information that you feel may help us better understand your child (e.g., additional school history):

_____

_____

Name of person filling out this form: _____

Signature: _____ Date: _____