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.

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

PRESCHOOL/KINDERGARTEN QUESTIONNAIRE

Child's name: _____ Birth date: _____

Parent/Guardian: _____

To the teacher: Your careful completion of this questionnaire, which will help us to assess this child's needs, is greatly appreciated. Please return to: _____

Name of preschool/kindergarten: _____ Contact name: _____

Address: _____ City/province: _____ Postal code: _____

Phone: _____ Fax: _____

Type of program

☐	Nursery school/preschool	☐	Half-day	☐	Regular
☐	Kindergarten	☐	Full-day	☐	Special needs

Date child was enrolled: _____ Who initiated this referral? _____

Please list any specific questions or concerns for which you would like help:

_____

_____

_____

_____

What are the child's greatest strengths?

_____

_____

What are the child's weaknesses or difficulties?

_____

_____

Describe the child's learning style (activity level, organizational skills, impulsiveness, etc.):

Describe the child's behaviour:

Describe the child's peer relationships and social interaction skills:

Which of the following resources are available to your school?

Professional	Consultant or agency	Is this child currently involved?
Special education teacher		
Special education assistant/aide		
Special education program		
Speech-language therapy		
Physiotherapy		
Occupational therapy		
Psychologist		
Community health nurse		
Social worker		
Other (specify)		

Please assess the child in the following areas:

Skill set	Major concern	Minor concern	No concern	Cannot judge	Comments
Gross motor skills					
Posture					
Awkward gait					
Frequently falls					
Easily fatigued					
Tip-toe walking					

Skill set	Major concern	Minor concern	No concern	Cannot judge	Comments
Gross motor skills (cont'd)					
Ball skills					
Playground skills					
Playground safety					
Coordination					
Other (specify)					
Fine motor skills					
Crayon/pencil skills					
Use of scissors					
Easily fatigued when printing					
Hand dominance (switching hands)					
Puzzle skills					
Other (specify)					
Self-help skills					
Undressing self					
Dressing self					
Use of zippers/buttons					
Feeding self					
Washing hands/face					
Helping clean up					
Toileting routines					
Toileting accidents/ soiling					
Other (specify)					
Social skills					
Interest in peers					
Initiation of interactions with peers					
Social responses to peers					
Group play with peers					
Imaginative play					
Solitary play					
Repetitive motor movements or behaviours (spinning, flapping, tics)					
Ability to share					
Turn-taking					

Skill set	Major concern	Minor concern	No concern	Cannot judge	Comments
Offering comfort					
Compliance with rules and limits					
Adjustment to new or changed routines					
Behaviour					
Attention span					
Impulsivity					
Hyperactivity or motor restlessness					
Physical aggression					
Destructive tendencies					
Temper tantrums					
Breath-holding spells					
Unusual fears					
Obsessive interests/ topics					
Ritual behaviours					
Phobias					
Somatic complaints (stomach aches, headaches, pains)					
Difficult temperament/ moods					
Other (specify)					
Receptive language skills					
Following 1-step instructions					
Following 2-step instructions					
Listening in a group					
Listening to stories					
Listening to rhymes and tunes					
Other (specify)					
Expressive language					
Pronunciation					
Speaking in phrases/ sentences					
Taking turns in conversation					

Skill set	Major concern	Minor concern	No concern	Cannot judge	Comments
Expressive language (cont'd)					
Effective verbal communication					
Stuttering					
Other (specify)					
Academic readiness skills					
Knowledge of sizes/ shapes					
Knowledge of colours					
Letter recognition					
Number recognition					
Rote count 1 to 10					
Knowledge of number concepts					
Ability to read and print first name					
Other (specify)					

Has there been a deterioration, loss, or plateauing of previously acquired skills in the past year?

No ❑ Yes ❑ (specify:) _____

General comments: _____

_____

_____

_____

Name of person filling out this form: _____ Title: _____

Signature: _____ Date: _____

Please attach copies of the child's latest assessment or progress reports and include any other information that might help in assessment of this child.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.