Hope Clinic on 5th
215 5th Ave. N
Saskatoon, SK S7K 2P2
Tel (306 954-3411 / Fax (306) 954-3418

Name & Relationship to Child (of Person Filling Out Form) _____

Date: _____

FAMILY INFORMATION FORM
Personal and Confidential

CHILD'S LEGAL NAME (in full) _____
(name as on SK Health Card) last name first middle

DATE of BIRTH: _____ Personal Health Number: _____

ADDRESS: _____
Street/Box Number City/Town Postal Code

PHONE NUMBER: Home: _____

Alternate Contact #: Work: _____mother Cell: _____mother

Work: _____father Cell: _____father

(Note: SK Health requires we have the following information from parent/caregivers as well)

Parent/Caregiver Names: _____
(names as on SK Health Card)

Personal Health Number: **Mother:** _____ **Father**: _____

Date of Birth: Mother: _____ Father: _____

Dear Parents/Caregivers:

The following information will be helpful in improving our understanding of your child. Please fill in the blanks as thoughtfully as possible – do not leave blanks. If you do not know an answer, write "don't know".

In your words, what are your concerns about your child?

_____

_____

_____

When did the problems first begin?

_____

Are there circumstances, past or present, in your family's life that you connect with the current difficulties?

_____

_____

Has your child suffered any significant losses?

What made you decide to seek help?

What have you done to attempt to improve the problem?

What changes would you like to see as a result of your contact here?

FAMILY INFORMATION

Parents living **with** child:

Father (Step) _____ Age: _____ Occupation: _____

Mother (Step) _____ Age: _____ Occupation: _____

Date of current union/marriage: _____

Parents living **apart** from child:

Father (Step) _____ Age: _____ Occupation: _____

Address: _____ Telephone: _____

In contact with the child? Yes _____ No _____ If 'Yes', how often? _____

Mother (Step) _____ Age: _____ Occupation: _____

Address: _____ Telephone: _____

In contact with the child? Yes _____ No _____ If 'Yes', how often? _____

Foster parents/guardians:

Father: _____ Age: _____ Occupation: _____

Mother: _____ Age: _____ Occupation: _____

How long has the child been in your home? _____

Is the Department of Social Services involved with your family? Yes ___ No ___

If Yes, Worker's Name _____ Phone: _____

Department of Social Services office: _____

List all other persons (including other children) who presently live in your home.

Name	Sex	Age	Relationship to Child	If child: is he/she biological, adopted, step or foster?	Occupation or Grade

CHILD'S MEDICAL HISTORY

Is your child on medication? Yes _____ No _____

If 'Yes', what medication?

_____

Does your child have any medication allergies? Yes _____ No _____

If 'Yes', please specify.

_____

Is your child physically well? Yes ___ No ___

(or) Does your child have any health problems currently? Yes ___ No ___

If yes, please specify:

Has your child ever had any of the following?

	Yes	No			Yes	No
Allergies				Hearing problems		
Bedwetting				Heart problems		
Broken bones				Learning Problems		
Clumsiness				Seizures		
Ear infections				Soiling		
Eating/Weight problems				Speech problems		
Head injury				Visual problems		

List any illnesses/injuries for which your child required hospitalisation and/or surgical operations.

Illness/Injury	Doctor	Date	Hospital

FAMILY MEDICAL HISTORY

Have any members of your family (state relationship to child) had any of the following problems?

	Yes	No	Who?			Yes	No	Who?
Alcohol/drug problems					Mood Disorder			
Anxiety					Schizophrenia			
Bedwetting					Seizures			
Family violence					Speech problems			
Hyperactivity					Soiling			
Learning problems					Suicide			
Mental retardation					Others?			

Is any member of the family currently ill? Yes _____ No _____ Don't know _____

If 'Yes', please explain:

_____

_____

Are any members of the family taking medications at the present time?
Yes _____ No _____ Don't know _____
If 'Yes', please explain:

_____

_____

DEVELOPMENTAL HISTORY

Pregnancy:
During the pregnancy, did the child's mother experience any illnesses, or accidents?

_____

_____

Were any drugs (prescription or non-prescription), alcohol, or tobacco taken during pregnancy?

_____

_____

Delivery:
Duration of pregnancy _____ Duration of labour _____ Birth weight _____

Describe any difficulties with the delivery (e.g. Caesarean Section, medication required, breech presentation etc.)

_____

_____

Following birth, did your child have trouble starting to breathe? _____

Was anything unusual at birth or in the first few weeks of life (jaundice, seizures etc.)?
Yes _____ No _____ If 'Yes', please specify:

_____

_____

Were developmental milestones like walking, talking, toilet training on track? Yes _____ No _____

If 'No', please specify: _____

_____

_____

PRESCHOOL HISTORY

List any pre-school programs and/or day care centres, or day homes your child has attended:

Name of Program	Child's Age	Length of time attended

Has your child's behavior been of any concern at the pre-school, day care, or day home?
Yes _____ No _____ If 'Yes', what were the concerns?

_____

_____

SCHOOL HISTORY

Name of present school: _____ Grade: _____ Teacher: _____

Other schools attended	City/Town/Province	Year(s)	Grade(s)	Age

Has your child repeated a grade? Yes _____ No _____ If 'Yes', please specify:

_____

_____

Has your child had frequent absences from school or been absent for more than one month?
Yes _____ No _____ If 'Yes' please specify:

_____

_____

Has your child's behavior been of any concern at elementary or high school?
Yes _____ No _____ If 'Yes', what were the concerns?

_____

Child & Adolescent Psychiatry

Have any psychiatrists, agencies or counselors been involved in your child's care?
Yes ____ No ____

If yes, please provide name(s) and date(s) of appointment(s):

Name of Psychiatrist/Counselor/Agency	Date(s) of Appointment(s)

Consent to Obtain and Release Information

The Child & Adolescent Psychiatrists in Saskatoon work together to provide patient care. To ensure that your child receives the best possible service, it may be necessary, from time to time, to communicate between offices on your behalf, both verbally and in writing, to other psychiatrists, physicians or professional mental health staff. All information obtained will remain confidential.

I give my consent for my child's psychiatrist to obtain and release information.

_____ _____
Patient's printed name *Patient's date of birth*

_____ _____
Signature of Parent or Legal Guardian *Parent/Legal Guardian's printed name*

_____
Date