West Island Therapy Centre | Le centre de thérapie West Island

Assessment Information for Derogation:

Date (dd/mm/yr):_____

Child's Name:_____Date of birth(dd/mm/yr): _____
Male/Female: _____Age:_____

Daycare/Pre-school:_____ Educator's name:_____
Phone number:_____

Form completed by:_____ Date_____
(name and relationship to client)

Address: _____

City: _____

Prov, Postal Code: _____

Home phone:_____

Father's Name_____ Age:____ Occupation:_____
cell:_____ e-mail: _____

Mother's Name_____ Age:____ Occupation: _____
cell:_____ e-mail: _____

Marital status of parents: _____

Is the child adopted? Yes No. If so, at what age? _____from which country _____

Other children in the home:

Name: _____ Age: _____

Name:_____ Age: _____

Name:_____ Age: _____

Emergency Contact Person:_____

Emergency Contact Phone Number:_____

Relationship to child:_____

FAMILY HISTORY:

Is there a family history of substance abuse in your family? Yes No
Please specify:_____

Name and describe those family members (immediate and extended) who have a history of behavior, learning, drugs/alcohol and/or psychiatric problems (depression, highs and lows, hyperactivity, major mental illness):

_____
_____
_____
_____
_____

PREGNANCY HISTORY – Mother

While pregnant with this child was the mother under a doctor's care? Yes No

Mother's health during pregnancy: _____ Good _____ Fair _____ Poor

If fair or poor, please describe:_____
_____

During the pregnancy were there any complications (i.e. bleeding, emotional stress, high blood pressure, fetal distress)?

_____
_____
_____

Length of pregnancy:_____ Birth weight:_____ Apgar Score: (Scale from 1-10) _____
Duration of labour:_____ Were forceps used? Yes No
Delivery was (check one) _____ Normal _____Breech _____ Caesarean

Were there any problems before or after delivery? Yes No If so, please describe:_____

DEVELOPMENTAL HISTORY:

As you can remember, were there any delays in the following areas?

Held head up:_____
Smiled:_____

Rolled over:_____
Crawled:_____
Sat alone:_____
Stood alone:_____
Walked unassisted:_____
Said words:_____
Fed self:_____
Buttoned clothes:_____
Toilet Trained:_____
Dressed alone:_____
Said alphabet:_____
Named colors:_____
Used sentences:_____
Began to read:_____
Tied shoes:_____
Rode bike:_____

Any feeding or eating problems? Explain:
_____
_____

Bottle-fed or Breast-fed :_____ Weaned at what age?_____

Any speech or language delays? Explain:
_____
_____

Any problems with toilet training? Explain:
_____
_____

List and describe any sleep problems (difficulty falling asleep; staying or returning asleep, nightmares) at the present time or in the past?
_____
_____
_____

MEDICAL HISTORY:

Name of child's pediatrician: _____ Phone number:_____

Comprehensive hearing test:
_____No
_____Yes Date Completed: _____ Results:_____

Visual Exam:
_____No
_____Yes Date Completed: _____ Results:_____

Is your child on any prescribed or over the counter mediations? Yes No
If so, what is the medicine, the dosage and how long has your child been on it?_____
_____
_____

List and explain your child's current or past medical or neurological problems. Include head injuries, seizures, heart problems, disabilities, asthma etc.
_____
_____
_____

Has your child ever been hospitalized: Yes No
If so, when and why?_____

Last Physical:_____ Child height:_____ Weight:_____

Please list and describe your child's general strengths.

_____
_____
_____
_____

Please list and describe your child's general weaknesses.

_____
_____
_____
_____

Please describe your child's current academic skills (e.g. can they identify letters and numbers, days of week, shapes etc.)
_____
_____
_____

<u>Records to bring to your consultation:</u>

1. Any written evaluations from daycare/pre-school.
2. Copies of any and all reports from psychologists, speech therapists, occupational therapists or pediatrician

Please complete this form and bring it with you to your first consultation with your psychologist.

Thank you.