Alberta Health Services

Pediatric Outpatient Services
Neurodevelopmental Clinics
Glenrose Rehabilitation Hospital
10230 – 111 Avenue
Edmonton, Alberta
Canada T5G 0B7
Office: (780) 735-7906
Fax: (780) 735-6293

Developmental History – Parent Questionnaire

- **Complete questionnaire and make a copy for your records.**
- **Return the completed parent questionnaire by MAIL, FAX or EMAIL**

Glenrose Rehabilition Hospital
Rm 0603 10230 111 Ave
Edmonton, AB T5G 0B7
Fax : 780 735 6293
Email : GRHPedsCentralIntake@albertahealthservices.ca

If you require more information, please contact one of our support staff at (780) 735-7906.

QUESTIONNAIRES MUST BE COMPLETED AND RETURNED AS SOON AS POSSIBLE

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Affix patient label here

Developmental History-Parent Questionnaire

COMPLETED FORMS MUST BE RETURNED BEFORE YOUR SCHEDULED APPOINTMENT

Please return completed questionnaire to:

Neurodevelopmental Clinics
Glenrose Rehabilitation Hospital
Room GE 0603, 10230-111 Avenue Edmonton, AB T5G 0B7
Phone: 780-735-7906 Fax: 780-735-6293

Name of child:	**DOB:**
Gender at Birth: ❒male ❒female ❒other	**Child's Preferred Pronouns:** He/him/his She/her/hers They/them/theirs
Name of Parent/guardian 1: Preferred Language: ❒English ❒other: _____ Interpreter Required: ❒Yes ❒No Phone number: _____ Email address: _____ Mailing Address:	**Name of Parent/guardian 2:** Preferred Language: ❒English ❒other: _____ Interpreter Required: ❒Yes ❒No Phone number: _____ Email address: _____ Mailing Address: ❒ same as parent/guardian 1
Are both guardians aware of this referral? ❒Yes ❒No	
Is your child under the care of Child and Family Services? ❒No ❒Yes →	Case Worker Name: Phone Number:
What are your main concerns about your child?	
What are your child's strengths and interests?	

Which community based services have you accessed? *Check all that apply. If possible, please provide documents with referral.*

Services	**Date (month/year)**	**Location**
❒Speech Language Pathology		
❒Occupational Therapy/Physical Therapy		
❒Audiology		
❒Early Intervention Program		
❒Mental Health Therapist		
❒Psychiatry		
❒Psychology		

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❒Other
Does your child attend any of the following programs? *Check all that apply.* **Type of Program** **Name of program:**
❒Daycare
❒Preschool/Kindergarten/School
❒Church Nursery/Sunday School
❒Library Programs
❒Sport/Recreation Programs
❒Community children's programs
❒Other
Child's Prenatal History
List any problems the mother had during pregnancy: (health, emotional, stressors)
How far into the pregnancy were you when you found out that you were pregnant? weeks
This was the mother's (#) pregnancy and (#) child. Length of pregnancy weeks
Were any of the following used during pregnancy: Cigarettes: Approximately pack(s) per day
Prescription/non-prescription medication:
Alcoholic beverages: ❒ First 3 months only ❒ Throughout most of the pregnancy Frequency: ❒ Once per week ❒ Two or more times per week
Amount each time (1 drink= 1 beer, 1 glass of wine or 1 mixed drink) ❒1-2 drinks ❒3-5 drinks ❒6 or more drinks
Non-medical drugs (marijuana, cocaine, heroin, etc):
Child's Birth History: Concerns During, Between and After Birth
Method of Delivery : ❒Spontaneous ❒Induced ❒Assisted (forceps) ❒Head First ❒Breech ❒Vaginal ❒Caesarean
Type of anesthetic : ❒ Put to sleep ❒ Other Birth Weight of Baby: Were there any concerns about the baby just before or after birth? (e.g. jaundice, low heart rate, lack of oxygen, infection) ❒ Yes ❒No If yes, please explain: Was the baby cared for in the Neonatal Intensive Care? ❒Yes ❒No If yes, how long was the hospital stay?

Health History (Please indicate child's age if answering "Yes")	
Ear Infections: ❒Yes ❒No	Tics or twitches: ❒Yes ❒No
Hearing Problems: ❒Yes ❒No	Frequent colds: ❒Yes ❒No
Asthma: ❒Yes ❒No	Allergies: ❒Yes ❒No
Eye or vision problems/glasses: ❒Yes ❒No	Sleep Difficulties: ❒Yes ❒No
Failure to thrive: ❒Yes ❒No	Feeding/eating problems: ❒Yes ❒No
Soiling pants: ❒Yes ❒No	Bedwetting: ❒Yes ❒No
Frequent stomach aches: ❒Yes ❒No	Unexplained Fevers: ❒Yes ❒No

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Has your child had any serious illnesses, (seizures, meningitis) serious injuries, (burns, falls, broken bones), hospitalizations or operations? ❒ Yes ❒ No If yes, please explain, including what, when and name of hospital.
List any current or previous medications and special diets, herbal remedies or large doses of vitamins: (For longer than 2 weeks)
1: Age:
2: Age:
3: Age:

Child's Developmental History				
Infant Temperament – During the first few years of life was your child:				
Cuddly	❒Yes	❒No		
A poor/restless sleeper	❒Yes	❒No		
Easily calmed by holding/stroking	❒Yes	❒No		
Overall mood: ❒"easy"	❒"variable"	❒"difficult"	❒other	
Early Development –At what age did your child first accomplish the following?				
Sit up alone:		Use fingers to feed:		
Crawl or bum scoot:		Use a spoon:		
Walk alone 10-15 steps:		Toilet trained:		
Wave:		Point:		
How much did your child babble?	❒None	❒A little	❒A lot	❒Constantly
At what age did your child say his/her first word?		Example:		
Put 2-3 words together?		Use sentences?		
For children under 5 years, how many words is the child presently saying? ❒0-10 ❒10-50 ❒>50				
If you cannot remember specific ages, were there concerns about your child's early development? ❒Yes ❒No If yes, explain:				

Parent History	**Parent/Guardian 1**	**Parent/Guardian 2**
	Identifies as: ❒ mother ❒ father ❒ other (grandparent, foster parent, adoptive parent, etc.)	Identifies as: ❒ mother ❒ father ❒ other (grandparent, foster parent, adoptive parent, etc.)
Name:		
Date of Birth: DD/MM/YY		
Present Occupation:		
Education: (highest grade completed)		
Any learning/attention/behavior difficulties?		
Attended a special class?		
Is Parent/Guardian a biological parent?	❒Yes ❒No	❒Yes ❒No
Are birth parents related to each other (by blood)? ❒Yes ❒No (if yes, relationship?)		

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Sibling History				
Sibling's Name	Birth date DD/MM/YY	Gender (Male/ Female/X)	Relationship (full, step, half, foster, adopted)	Any Health/ Behavior/ Learning Difficulties?

Health Conditions in the Birth Family	
Please check all items that apply and state how the person is related to this child. Indicate on which side of the birth parent's side of the family (for example: mother's aunt, parent 2's father, etc).	
	Relationship to child
❒Genetic syndrome	
❒Learning difficulties	
❒Attention Deficit Hyperactivity Disorder (ADHD)	
❒Tics or Tourette's disorder	
❒Cerebral Palsy	
❒Autism	
❒Migraine headache	
❒Epilepsy	
❒Intellectual impairment/developmental delay	
❒Thyroid problem	
❒Sickle cell Anemia/Thalassemia	
❒Tuberculosis	
❒Speech difficulties	
❒Hearing impairment	
❒Visual impairment	
❒Behavioral difficulties in childhood	
❒Alcohol use	
❒Drug/Substance use	
❒Emotional/psychiatric disorder	
❒Other difficulties	
Please indicate any recent significant family events, concerns or issues that could be influencing your child's functioning. (e.g. At home, at work, housing, finances):	

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Behavior/Discipline		
Do you have any concerns about your child's behavior? ❒Yes ❒No		
If yes, please explain which specific behaviors concern you?		
Describe how you discipline your child?		
Additional information that may help us better understand your child:		
Signature	**Relationship**	**Date:**

Your health information is being collected under the authority of section 20(b) of the Health Information Act. The collection of your personal health number is authorized the section 21(1) of the Health Information Act. The provisions of the Health Information Act protect the confidentiality of this health information and your privacy. Your health information will be used to determine your eligibility for health services to provide you with health services and to carry out purposes that Alberta Health Services is authorized to carry out under legislation that governs its activities.