Hôtel-Dieu Grace Healthcare

CHART #: __________

# REGIONAL CHILDREN'S CENTRE

## PARENT / CAREGIVER INFORMATION FORM

The purpose of this questionnaire is to obtain a comprehensive view of your child's background. Please complete these questions as fully and as accurately as you can. The questionnaire is long and detailed. However, people's lives are complex. In order to help, we need to understand your child's life situation. If you need help completing this form please call us at (519) 257-5215.

Your answers to the following questions will be regarded as confidential information, as in any other information you may give Regional Children's Centre (RCC). If more space is needed, use the back of the form or attach extra sheets. The more information you are able to provide, the better understanding we will have of the problem you are facing.

Upon completion, we ask that you please drop-off or mail this information form to:
**Regional Children's Centre**
**3901 Connaught St.**
**Windsor, Ontario N9C 4H4**
**ATTN: Front Reception**

**IDENTIFYING INFORMATION:**

Date Form Completed: ____________________ Child's Date of Birth: ____________________

Child's Legal Name: ________________________________________ Sex: M F
(First / Middle / Last)

Child's Address: ________________________________________
Street City Province Postal Code

Child's Home Phone Number: ____________________

Name of person completing form: ____________________ Relationship to child: ______________

**Parent / Caregiver's Name:** ____________________ Relationship to child: ______________
Place of Employment: ____________________ Work Phone#: ______________
Can you be contacted at work? ☐ Yes ☐ No Cell Phone #: ______________

If address is different from identified child, please provide the following:

________________________________________
Street City Province Postal Code Phone Number

* * * * * * * * * * * * * * *

**Parent / Caregiver's Name:** ____________________ Relationship to child: ______________
Place of Employment: ____________________ Work Phone #: ______________
Can you be contacted at work? ☐ Yes ☐ No Cell Phone #: ______________

If address is different from identified child, please provide the following:

________________________________________
Street City Province Postal Code Phone Number

**Parent / Caregiver's Name:** ______________________ Relationship to child: ____________
Place of Employment: ______________________ Work Phone #: ____________
Can you be contacted at work? ☐ Yes ☐ No Cell Phone #: ____________

If address is different from identified child, please provide the following:

| Street | City | Province | Postal Code | Phone Number |
|---|---|---|---|---|
| | | | | |

* * * * * * * * * * * * * * *

**Parent / Caregiver's Name:** ______________________ Relationship to child: ____________
Place of Employment: ______________________ Work Phone #: ____________
Can you be contacted at work? ☐ Yes ☐ No Cell Phone #: ____________

If address is different from identified child, please provide the following:

| Street | City | Province | Postal Code | Phone Number |
|---|---|---|---|---|
| | | | | |

* * * * * * * * * * * * * * * *

**Who lives with the child?**

| Name | Date of Birth | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**If separated or divorced please list those who live in the other parent's home:**

| Name | Date of Birth | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Significant Others** (name and relationship): ______________________________

______________________________________________

**Does this child have siblings (full or step-siblings) who are currently receiving services through RCC?**
**If so, name of Service Co-ordinator?**______________________________

**CUSTODY: (Please complete the following section, if applicable)**

1. If parents of the child are separated or divorced, for how long? ______________________

2. Are you currently involved in any legal proceeding regarding custody / access? ☐Yes ☐No

3. Is there a legal custody agreement? ☐Yes ☐No
   Type: ☐ Sole Custody
   ☐ Joint Custody
   ☐ Interim Custody
   Please provide comments on custody / visitation arrangements: ______________________

4. Who is the child's legal guardian? ______________________

5. Please indicate date of marriages, separations and common-law unions:
   ______________________ Date: ______________________
   ______________________ Date: ______________________
   ______________________ Date: ______________________

6. Has the Children's Aid Society (CAS) ever been involved with you or your family:
   If so, please describe: ______________________

7. Has your child ever been placed in foster care / group home? ☐Yes ☐No
   Dates: ______________________

8. If currently involved with CAS, please provide names of worker(s): ______________________

**CONCERNS:** Identify and rate your concerns as follows:
1 = Past
2 = Current (occurred in the last six months)
Blank = Has not occurred

| 1 | 2 | |
|---|---|---|
| ☐ | ☐ | Parent child conflict/child management problems |
| ☐ | ☐ | Problems with peers (please specify): ________________ |
| ☐ | ☐ | Anxious mood: ☐ Worries, fears, panic ☐ Separation anxiety |
| ☐ | ☐ | Obsessions and compulsions |
| ☐ | ☐ | Depressed mood |
| ☐ | ☐ | Self-injury |
| ☐ | ☐ | Suicidal thinking |
| ☐ | ☐ | Suicide attempt - (date): ________________ |
| ☐ | ☐ | Manic symptoms |
| ☐ | ☐ | Physical complaints (i.e. headaches, stomachaches) |
| ☐ | ☐ | Sleep difficulties (nightmares, trouble falling / staying asleep, trouble waking) |
| ☐ | ☐ | Concerns with eating habits (i.e. skips meals, overeating) |
| ☐ | ☐ | Sexual identity / gender identity issues causing distress |
| ☐ | ☐ | School issues: ☐ Poor attendance or school refusal<br>☐ Suspensions or expelled<br>☐ Academic difficulties / learning difficulties / or poor grades |
| ☐ | ☐ | Attention and concentration concerns |
| ☐ | ☐ | Hyperactivity |
| ☐ | ☐ | Sensory sensitivity |
| ☐ | ☐ | Developmental or intellectual disability |
| ☐ | ☐ | Autism – Diagnosed by: ________________ |
| ☐ | ☐ | Hallucinations (sees or hears things that are not real) |
| ☐ | ☐ | Delusional or bizarre thinking |
| ☐ | ☐ | Oppositional or defiant behaviour |
| ☐ | ☐ | Running away from home |
| ☐ | ☐ | Aggression (physical or verbal) |
| ☐ | ☐ | Tantrums |
| ☐ | ☐ | Destructive behaviour |
| ☐ | ☐ | Inappropriate sexual behaviour |
| ☐ | ☐ | Fire setting: Date of incident ________________ |
| ☐ | ☐ | Cruel to animals |
| ☐ | ☐ | Unlawful behaviour (please specify): ________________ |
| ☐ | ☐ | Drug or alcohol use |
| ☐ | ☐ | Internet / computer / video game addiction |
| ☐ | ☐ | Abuse: ☐ Physical ☐ Emotional ☐ Sexual ☐ Domestic Violence |
| ☐ | ☐ | Neglect |
| ☐ | ☐ | Traumatic experience (please specify): ________________ |
| ☐ | ☐ | Significant health problems (please specify): ________________ |
| ☐ | ☐ | Physical disability (please specify): ________________ |
| ☐ | ☐ | Toileting issues: ☐ Wetting ☐ Soiling |
| ☐ | ☐ | Family stressors: ☐ Divorce / separation / blended family adjustment difficulties<br>☐ Financial stress<br>☐ Multiple moves<br>☐ Parent / caregiver: ☐ Mental health issues ☐ Substance abuse<br>☐ Family member involved with legal system for criminal or illegal activities |

| For Office Use Only: | | | |
|---|---|---|---|
| ☐ Ability Related | ☐ Externalized | ☐ Internalized | ☐ Situational |
| Status: | ☐ Crisis | ☐ Priority | ☐ Regular |

## REASONS FOR SEEKING SERVICES FROM WINDSOR REGIONAL CHILDREN'S CENTRE

1. Please describe below your concerns about social, emotional or behavioural difficulties (e.g., self-esteem, anxiety issues, aggressiveness, peer problems, temper tantrums, withdrawal, depression, drug / alcohol abuse, sexual acting out, non-compliance). Describe in detail:

   a. At home / with family: ______________________________

   b. At school: ______________________________

   c. In the community: ______________________________

2. When were the concerns first noted? ______________________________

3. Does your child exhibit any unlawful behaviour (e.g., vandalism, break and enter, arson, sexual assault)? Has there been contact with police services in the last year? _______ If yes, nature of contact?

4. Has your child ever self-injured? Has your child ever indicated suicidal thoughts? Has your child ever made a suicide attempt? Are these issues in the past, present, or both?

5. Crisis / Safety Plan ______________________________

6.. Does your child have any possible or confirmed problems related to development (e.g., autism, developmental disability, delayed milestones, poorly developed self-help skills)?

7.. What are your child's strengths?

## SCHOOL HISTORY:

School: ____________ Grade/Special Program: ____________

Number of High School Credits: _____ Does your child have an IEP? ☐ IPRC? ☐

1. Are there currently any school personnel involved with your child (i.e.: Child & Youth Worker, Social Worker, Educational Assistant, Behavioural Specialist, etc)? ☐Yes ☐No
   If so, who?
   Reason for involvement:

2. In what grade did school problems become noticeable?

3. Describe any special education your child may have received:

4. Which schools has your child attended? Please list:

5. Did your child attend?

| | | | |
|---|---|---|---|
| | Daycare | ☐ Yes | ☐ No |
| | Junior & Senior Kindergarten | ☐ Yes | ☐ No |

## CHILD'S HEALTH / MENTAL HEALTH:

Family Physician: ______________________ Pediatrician: ______________________

Psychiatrist: ______________________ Prescription Plan Coverage: ______________

Health Card No.: ______________________ Version Code: _____

Allergies: ______________________

1. Please indicate (where applicable):

| | Date | Where/By Whom | Results |
|---|---|---|---|
| Last physical exam | | | |
| Vision Test | | | |
| Hearing/CAP testing | | | |
| Other (Labwork, EKG) | | | |

2. Has your child had any of the following assessments? Please attach reports (if available).

| | Date | By Whom | Diagnosis |
|---|---|---|---|
| Psychiatric | | | |
| Neuropsychological | | | |
| Psychological | | | |
| Speech/Language | | | |
| Behavioural | | | |
| Medical (e.g., EEG, CAT, MRI) | | | |

3. List any medication(s) your child is currently taking (please include dosage[s] if known): ______________

4. What medication(s) have been tried with your child in the past? ______________

5. Which (if any) children's mental health centre(s) has the child been involved with, for what purpose, and for how long: ______________

6. Are you <u>currently</u> receiving help from another agency? If so, please describe: ______________

**FAMILY HISTORY** (Please include immediate and extended family members):

1. Has anyone in your child's family ever experienced or been treated for:

| | | | Relationship to Child |
|---|---|---|---|
| **Anxiety Disorder** (e.g., Generalized Anxiety Disorder, Separation Anxiety, Phobias, Social Phobias, Panic Disorder, or OCD) | ☐ Yes | ☐ No | ______ |
| **Depression** | ☐ Yes | ☐ No | ______ |
| **Suicide** (attempted / completed) | ☐ Yes | ☐ No | ______ |
| **Bipolar Disorder** (e.g., Mania, Manic-Depression) | ☐ Yes | ☐ No | ______ |
| **Psychotic Disorder** (e.g., Schizophrenia, Delusional Disorder) | ☐ Yes | ☐ No | ______ |
| **Learning Disorder** (Attention Deficit Hyperactive Disorder / ADHD, Attention Deficit Disorder/ADD) | ☐ Yes | ☐ No | ______ |
| **Autism Related Disorder** (e.g., Autism, Asperger's, PDD – NOS) | ☐ Yes | ☐ No | ______ |
| **Other** | ☐ Yes | ☐ No | ______ |

2. Often family problems and stressors complicate children's behavioural difficulties. Have you experienced any family problems or stressors that you think may have led to or worsened the current behavioural concerns? Please describe: ______

3. Have you or anyone in your family had a past or present issue with alcohol or drugs? Please include abuse of prescription medication. Please describe: ______

4. Have you or anyone in your family ever been sexually abused / assaulted? Please describe: ______

5. Have you or anyone in your family ever been physically abused? Please describe: ______

6. Have you or anyone in your family ever witnessed family violence? Please describe: ______

**FAMILY CULTURE:**

1. Do parents / caregivers agree on how to parent the child? ____________________

2. What languages are spoken in the home? ____________________

3. Are religious, lifestyle, and ethnic values important in your home? ☐ Yes ☐ No
   Please describe: ____________________

4. What are your family's strengths? ____________________

5. Please describe your support network: ____________________

**TREATMENT DIRECTION:**

1. How do you feel we can help your child and family? What family members are willing to be involved in services? What changes are you hoping to see? ____________________

2. Is there anything that may interfere with your participation in treatment (e.g., work, finances, babysitting, illnesses, vacation, language barrier, physical and / or other disability)? ____________________

3. Other comments / concerns we did not ask about? ____________________