UNIVERSITY OF CALGARY

WERKLUND SCHOOL OF EDUCATION

Centre for Wellbeing in Education, Clinical Services
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CENTRE FOR WELLBEING IN EDUCATION – CLINICAL SERVICES
FAMILY HISTORY FORM

Use of Family History Information

The Centre for Wellbeing Clinic provides psychoeducational assessments for children, approximately 5 to 20 years of age, including those transitioning into and out of K – 12 schooling. Ideal clients are school-aged children for whom there are questions about their learning and their academic skill development.

Referral questions appropriate for clinic clients might include:

- Does my child have a learning disability?
- Is my child gifted?
- What are my teenager's academic and cognitive strengths and weaknesses?
- Are my child's attention issues unusual for her/his age?
- What educational recommendations will be helpful for my adolescent who is just starting high school?

Please ensure all information provided is correct, current, and as complete as possible.

This information is collected under the authority of s. 33 (c) of the *Freedom of Information and Protection of Privacy Act.* It is required to evaluate your application for psychoeducational assessment at the clinic. If your child is accepted for assessment, the information will be used along with other sources of data to better understand how he/she learns, processes information and functions emotionally and behaviorally.

If you have any questions about the collection or use of this information, please contact the Administrative Coordinator by phone 403-220-2851 or email: werklundcentre@ucalgary.ca

Today's Date	**Parent/Guardian Completing this Form**

The Clinic offers psychoeducational assessment, intervention, and counselling and therapy programs. Would you like to receive information about programs or services offered by the Clinic in the future?

☐ Yes, please email me with future Centre for Wellbeing opportunities
☐ No, do not email me with future Centre for Wellbeing opportunities

PERSONAL INFORMATION FOR CLIENT		
Name of Child:		
Child identifies as: ☐ Male ☐ Female ☐ Other	Date of Birth:	Current Age:
Current Grade:	School:	
School Type (Ex: Public, Christian, Alternative, Online, Specialized program, etc.):		

Parent/Guardian Information

With whom does this child live:

☐ Both parents ☐ Parent #1 ☐ Parent #2

☐ Other (specify):

This child's parents are:

☐ Married ☐ Separated Year: _____
☐ Living together ☐ Divorced Year: _____
☐ Mother deceased ☐ Father deceased ☐ Other: _____

Is this child adopted or a foster child?

Adopted ☐ Yes ☐ No | Fostered ☐ Yes ☐ No

If you checked YES to one of the above, when did this child become part of the family?

When a psychologist is providing professional services to a child who is a minor, the psychologist must obtain informed consent from the minor's parent/guardian. Generally, a psychologist is not required to obtain informed consent from both of the parents since either parent normally has the right to consent to services for the child. However, *if the parents are separated or divorced*, the psychologist must make appropriate inquiries to ensure that the adult requesting services is the child's legal parent/guardian. It is recommended by the College of Alberta Psychologists that psychologists obtain relevant court documentation prior to commencing services.

As a result of this requirement, the Clinic will request to view custody/access documentation pertaining to child clients. Also, should a custodial parent be unable/unwilling to participate in the service delivery process, they will be asked to provide a written (email) statement to that effect.

Name of Parent #1/Guardian:	
Address:	
City/Town:	Postal code:
Day phone:	Evening phone:
Email address:	

Name of Parent #2/Guardian:	
Address:	
City/Town:	Postal code:
Day phone:	Evening phone:
Email address:	

Physician Information	
Family doctor:	Phone number:
Pediatrician:	Phone number:

FAMILY LIFE			
Please list <u>all</u> members of this child's <u>primary</u> household, including adults and children.			
Name:	Age	Relationship to child	Education/grade completion

Please list this child's close family members who are living in another household, including half-siblings, step-parents, etc. (if applicable):			
Name	Age	Relationship to child	Education/grade completion

What is the primary language spoken at home:

Please list any languages, other than English, that are spoken at home:

FAMILY HISTORY

How many times has this child moved in the past 5 years? _____

How long has this child lived at the present address? _____

Parent Employment History				
	Name of company	Occupation	Years at primary job	Any other jobs?
Parent/Guardian #1 Name:				
Parent/Guardian #2 Name:				

Other:				
Other:				

Please check box if a <u>family member(s)</u> has/have a history of difficulty in any of the following areas:	Please specify relationship(s) to this child:	Comments:
☐ Trouble with reading		
☐ Trouble with writing		
☐ Trouble with spelling		
☐ Trouble with math		
☐ Speech problems		
☐ Significant health concerns		
☐ Hyperactivity		
☐ Behavioral problems as a child		
☐ Legal troubles as a teen		
☐ Depression		
☐ Anxiety		
☐ Other mental illness		
☐ Drinking or drug abuse		
☐ Other: _____		
Comments:		

PREGNANCY & BIRTH HISTORY
Was this pregnancy planned? ☐ Yes ☐ No How many weeks was the pregnancy? _____ APGAR score (if known): _____

Please check all that apply:			
☐	Birth mother experienced problems during pregnancy Ex: bleeding, infections, seizures, toxemia, pre-eclampsia, etc.	☐	Health problems at birth Ex: jaundice, seizures, anoxia
☐	Birth mother had medical/health problems after birth	☐	Prescribed medication taken during pregnancy
☐	Planned C-Section	☐	Labor was induced
☐	Health problems the first few weeks after birth Ex: feeding, skin rashes, breathing difficulties, problems with bowel movements or passing urine	☐	Complicated labor and/or delivery Ex: long labor, unusual presentation, C-Section, cord around neck, breathing problems, etc.
☐ Other:			

If you checked YES to any of the above, please provide further details:
Did the birth mother drink alcohol during this pregnancy? ☐ No ☐ Yes Drinks per week? _____ If yes, what week in the pregnancy did the birth mother stop drinking alcohol? _____
Did the birth mother smoke cigarettes or use any drugs during this pregnancy? ☐ No ☐ Yes If yes, how many cigarettes per week? _____

How many instances of drug use did she have? _____
Other comments:

DEVELOPMENTAL HISTORY

How old was this child when he/she was able to:	0-3 mo.	4-6 mo.	7-12 mo.	13-18 mo.	19-24 mo.	2-3 yrs.	4-5 yrs.	Does not have skill
Sit up without help	☐	☐	☐	☐	☐	☐	☐	☐
Crawl	☐	☐	☐	☐	☐	☐	☐	☐
Walk without help	☐	☐	☐	☐	☐	☐	☐	☐
Babble	☐	☐	☐	☐	☐	☐	☐	☐
Say first word (mama, dada, etc)	☐	☐	☐	☐	☐	☐	☐	☐
Speak 2-3 word sentences	☐	☐	☐	☐	☐	☐	☐	☐
Responsive smile	☐	☐	☐	☐	☐	☐	☐	☐
Respond to his/her name	☐	☐	☐	☐	☐	☐	☐	☐
Finger feed	☐	☐	☐	☐	☐	☐	☐	☐
Drink from a cup unassisted	☐	☐	☐	☐	☐	☐	☐	☐
Use a spoon	☐	☐	☐	☐	☐	☐	☐	☐
Fully bladder trained	☐	☐	☐	☐	☐	☐	☐	☐
Fully bowel trained	☐	☐	☐	☐	☐	☐	☐	☐
Dress without help	☐	☐	☐	☐	☐	☐	☐	☐
Throw or catch a ball	☐	☐	☐	☐	☐	☐	☐	☐
Follow 2-step instructions	☐	☐	☐	☐	☐	☐	☐	☐
Ride a tricycle	☐	☐	☐	☐	☐	☐	☐	☐

Did you have concerns about this child's development in areas of language, motor, social, or emotional development? ☐ No ☐ Yes

If yes, please specify:

Has this child had any of the following assessments?		
	Yes	Reason for service and approximate date
Occupational therapy	☐	
Speech and language	☐	

Psychology	☐	
Physiotherapy	☐	
Other	☐	

Does this child have any current diagnoses? ☐ No ☐ Yes

If yes, please specify:

Have you received services to help with learning, medical, mental health, or family concerns?

☐ No ☐ Yes

If yes, please specify type of service and dates attended:

HEALTH HISTORY

Has this child experienced any of the following heath concerns? Please check all that apply			
☐	Recurring health concerns Ex: ear infections, seizures, high fever, slow weight gain, asthma, heart problems	☐	Daytime bathroom accidents Ex: urination or defecation
☐	Hospitalization	☐	Nighttime bathroom accidents
☐	Complains about aches and pains Ex: headaches, stomachaches	☐	Irregular or unusual bowel movements
☐	Prescribed medications (please list): _____ _____	☐	Head Injury Ex: black-out, concussion Length of injury (if applicable): _____
☐	Tics Ex: recurrent off sounds, grunts, eye or nose twitches	☐	Prescribed glasses
☐	Repetitive motor movements	☐	Tubes in ears
☐	Allergies	☐	Other:

If you checked YES to any of the above, please provide further details:

Date of last vision exam and results:	Date of last hearing exam and results:

BEHAVIOUR HISTORY				
Please check the appropriate boxes that best describe this child's behavior as an infant:				
☐ Happy	☐ Irritable	☐ Cried a lot	☐ Fussy	☐ Colic
Anything else:				

Please check the appropriate boxes that best describe this child's current eating patterns:			
☐	Poor appetite	☐	Will not try new foods
☐	Difficulty staying seated at table	☐	Extreme hunger
☐	Eating non-foods (dirt, plastic, etc.)	☐	Other:

Please check the appropriate boxes that best describe this child's current sleeping patterns:			
☐	Has trouble falling asleep	☐	Wakes in the night
☐	Has nightmares or sleep terror	☐	Breaths loudly/snores in sleep
☐	Trouble waking from sleep	☐	Other:

Where does this child sleep?
How many hours of sleep does this child get at night?

Please check the appropriate boxes if this child demonstrates problems in any of the following areas:			
☐	Does not pay attention or is easily distracted	☐	Fails to finish things he/she starts
☐	Restless	☐	Impulsive
☐	Frustrated	☐	Impatient
☐	Cries easily	☐	Low self-esteem
☐	Anxious or nervous	☐	Has talked about suicide
☐	Uncooperative	☐	A danger to self or others
☐	Refuses to start or finish homework	☐	Conflict with siblings
☐	Other: Click here to enter text.		

If you checked YES to any of the above, please provide further details:

Do you have any other concerns about this child's behavior at home or at school? Please explain:
What is your method of discipline?
What are this child's responsibilities at home?

INTERESTS AND ACTIVITIES

How many hours per week does this child: Watch TV _____ Spend on the computer: _____ Play electronic video games: _____
What are this child's interests?
What are this child's strengths?
List clubs, lessons or organized sports in which this child participates:

SOCIAL SKILLS

Please check the appropriate boxes if this child demonstrates problems in any of the following areas:			
☐	Showing interest in others	☐	Understanding social rules
☐	Making friends	☐	Getting along with adults
☐	Keeping friends	☐	Getting along with peers
☐	Taking turns	☐	Sharing and cooperating
☐	Standing up for self	☐	Dealing with changes in routine
☐	Managing anger	☐	Over-reacting to sights or noises
☐	Being invited to play by other child	☐	Over-reacting to touch, taste or smell
☐	Insisting on routines	☐	Insisting on following rules
☐	Engaging in "give and take" conversations	☐	Other: Click here to enter text.

If you checked YES to any of the above, please provide further details:
Do you have any other concerns about this child's social skills? Please explain:

EDUCATIONAL/SCHOOL HISTORY	
Name of current school:	Name of current teacher(s):

Please detail this child's school history starting with the most recent placement:		
Name of school attended	Location	Grades/Years

Please check all that apply to this child:			
☐	Repeated a grade	☐	Failed courses at school
☐	Attended/attends French Immersion Grades:	☐	Attended school in language other than English and French
☐	Received special placement/support	☐	Was often in trouble
☐	Received special accommodation at school Ex: extra time/scribe for examinations, spellchecker, computer with word processing	☐	Have been told this child has a learning disability/learning difficulties or an attention disorder
☐ Other:			

If you checked YES to any of the above, please provide further details:
Are you aware that this child's teacher has any concerns? ☐ Yes ☐No If yes, please specify:

Please rate this child on the following:						
ACADEMIC						
	Very strong	Strong	No problem	Minor problem	Moderate problem	Severe problem
Higher-level thinking Ex: creating original ideas, good problem-solving strategies, using logic, forming new concepts	☐	☐	☐	☐	☐	☐
Reading	☐	☐	☐	☐	☐	☐
Spelling	☐	☐	☐	☐	☐	☐
Math	☐	☐	☐	☐	☐	☐
Written language output	☐	☐	☐	☐	☐	☐
Artistic	☐	☐	☐	☐	☐	☐
Athletic	☐	☐	☐	☐	☐	☐
GENERAL						
Relationship with teacher	☐	☐	☐	☐	☐	☐
Relationship with peers	☐	☐	☐	☐	☐	☐
Bullying by peers	☐	☐	☐	☐	☐	☐
Motivation	☐	☐	☐	☐	☐	☐
Enjoyment of school	☐	☐	☐	☐	☐	☐
Study skills	☐	☐	☐	☐	☐	☐
Memory	☐	☐	☐	☐	☐	☐
Organization	☐	☐	☐	☐	☐	☐
Comments:						

Do you have any further comments or information you feel might be useful in understanding this child's history and current functioning?

REASON FOR REFERRAL – MUST PROVIDE

Please list any questions you would like answered through this assessment?

If this child is not living with both biological parents, all court documents pertaining to custody and decision-making authority should be brought to the first appointment.

Parents/guardians may also bring copies of report cards, previous assessment reports, and /or other relevant documentation that might assist with the current evaluation.

Thank you for taking the time to complete this form. Once your application has been screened, the Administrative Assistant will notify you of your eligibility.