
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.

The University of Calgary (UCalgary) respects your privacy and is committed to ensuring the privacy of all students, staff, and community members. Your personal information is being collected under the authority of section 4(c) of the *Protection of Privacy Act*, SA 2024, c P-28.5 (POPA). Your personal information will be used for the registration, coordination, and administration of the UCalgary CWE Clinical Services program, including for program evaluation, quality assurance and quality improvement purposes.

We recognize the sensitive nature of your personal information and are committed to the protection of your privacy. UCalgary will treat your personal information as confidential at all times and will make reasonable security arrangements against such risks as unauthorized access to, collection, use, disclosure or destruction in accordance with POPA. Access to your personal information will be restricted to a limited number of designated individuals and your personal information will only be disclosed in de-identified form, or as otherwise permitted under POPA.

If you have any questions regarding this notice or the collection, use or disclosure of your personal information, please contact the Administrative Assistant at werklundcentre@ucalgary.ca, phone 403-220-2851, or in Clinic at EDT 408, 2500 University Drive NW, Calgary, AB, or contact the UCalgary Access and Privacy Office at accessandprivacy@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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Date of Birth:	Current Age:
Current Grade:	School:	
School Type (Please select): <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Alternative (Please Specify): _____ <input type="checkbox"/> Catholic <input type="checkbox"/> Other (Please specify): _____	Language of Instruction:	

Parent/Guardian Information
With whom does this child live: <input type="checkbox"/> Both parents <input type="checkbox"/> Parent #1 <input type="checkbox"/> Parent #2 <input type="checkbox"/> Other (specify): _____
This child's parents are: <input type="checkbox"/> Married <input type="checkbox"/> Separated Year: _____ <input type="checkbox"/> Living together <input type="checkbox"/> Divorced Year: _____ <input type="checkbox"/> Mother deceased <input type="checkbox"/> Father deceased <input type="checkbox"/> Other: _____
Is this child adopted or a foster child? Adopted <input type="checkbox"/> Yes <input type="checkbox"/> No Fostered <input type="checkbox"/> Yes <input type="checkbox"/> 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 all members of this child's primary 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:
<input type="checkbox"/> Trouble with reading		
<input type="checkbox"/> Trouble with writing		
<input type="checkbox"/> Trouble with spelling		
<input type="checkbox"/> Trouble with math		
<input type="checkbox"/> Speech problems		
<input type="checkbox"/> Significant health concerns		
<input type="checkbox"/> Hyperactivity		
<input type="checkbox"/> Behavioral problems as a child		
<input type="checkbox"/> Legal troubles as a teen		
<input type="checkbox"/> Depression		
<input type="checkbox"/> Anxiety		
<input type="checkbox"/> Other mental illness		
<input type="checkbox"/> Drinking or drug abuse		
<input type="checkbox"/> 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:

<input type="checkbox"/>	Birth mother experienced problems during pregnancy Ex: bleeding, infections, seizures, toxemia, pre-eclampsia, etc.	<input type="checkbox"/>	Health problems at birth Ex: jaundice, seizures, anoxia
<input type="checkbox"/>	Birth mother had medical/health problems after birth	<input type="checkbox"/>	Prescribed medication taken during pregnancy
<input type="checkbox"/>	Planned C-Section	<input type="checkbox"/>	Labor was induced
<input type="checkbox"/>	Health problems the first few weeks after birth Ex: feeding, skin rashes, breathing difficulties, problems with bowel movements or passing urine	<input type="checkbox"/>	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? _____

If yes, 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	<input type="checkbox"/>							
Crawl	<input type="checkbox"/>							
Walk without help	<input type="checkbox"/>							
Babble	<input type="checkbox"/>							
Say first word (mama, dada, etc)	<input type="checkbox"/>							
Speak 2-3 word sentences	<input type="checkbox"/>							
Responsive smile	<input type="checkbox"/>							
Respond to his/her name	<input type="checkbox"/>							
Finger feed	<input type="checkbox"/>							
Drink from a cup unassisted	<input type="checkbox"/>							
Use a spoon	<input type="checkbox"/>							
Fully bladder trained	<input type="checkbox"/>							
Fully bowel trained	<input type="checkbox"/>							
Dress without help	<input type="checkbox"/>							
Throw or catch a ball	<input type="checkbox"/>							
Follow 2-step instructions	<input type="checkbox"/>							
Ride a tricycle	<input type="checkbox"/>							

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	<input type="checkbox"/>	
Speech and language	<input type="checkbox"/>	
Psychology	<input type="checkbox"/>	
Physiotherapy	<input type="checkbox"/>	
Other	<input type="checkbox"/>	

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 health concerns? Please check all that apply

<input type="checkbox"/>	Recurring health concerns Ex: ear infections, seizures, high fever, slow weight gain, asthma, heart problems	<input type="checkbox"/>	Daytime bathroom accidents Ex: urination or defecation
<input type="checkbox"/>	Hospitalization	<input type="checkbox"/>	Nighttime bathroom accidents
<input type="checkbox"/>	Complains about aches and pains Ex: headaches, stomachaches	<input type="checkbox"/>	Irregular or unusual bowel movements
<input type="checkbox"/>	Prescribed medications (please list): _____	<input type="checkbox"/>	Head Injury Ex: black-out, concussion Length of injury (if applicable): _____
<input type="checkbox"/>	Tics Ex: recurrent eye sounds, grunts, eye or nose twitches	<input type="checkbox"/>	Prescribed glasses
<input type="checkbox"/>	Repetitive motor movements	<input type="checkbox"/>	Tubes in ears
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	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:

<input type="checkbox"/> Happy	<input type="checkbox"/> Irritable	<input type="checkbox"/> Cried a lot	<input type="checkbox"/> Fussy	<input type="checkbox"/> Colic
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Anything else:

Please check the appropriate boxes that best describe this child's current eating patterns:

<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	Will not try new foods
<input type="checkbox"/>	Difficulty staying seated at table	<input type="checkbox"/>	Extreme hunger
<input type="checkbox"/>	Eating non-foods (dirt, plastic, etc.)	<input type="checkbox"/>	Other:

Please check the appropriate boxes that best describe this child's current sleeping patterns:

<input type="checkbox"/>	Has trouble falling asleep	<input type="checkbox"/>	Wakes in the night
<input type="checkbox"/>	Has nightmares or sleep terror	<input type="checkbox"/>	Breaths loudly/snores in sleep
<input type="checkbox"/>	Trouble waking from sleep	<input type="checkbox"/>	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:

<input type="checkbox"/>	Does not pay attention or is easily distracted	<input type="checkbox"/>	Fails to finish things he/she starts
<input type="checkbox"/>	Restless	<input type="checkbox"/>	Impulsive
<input type="checkbox"/>	Frustrated	<input type="checkbox"/>	Impatient
<input type="checkbox"/>	Cries easily	<input type="checkbox"/>	Low self-esteem
<input type="checkbox"/>	Anxious or nervous	<input type="checkbox"/>	Has talked about suicide
<input type="checkbox"/>	Uncooperative	<input type="checkbox"/>	A danger to self or others
<input type="checkbox"/>	Refuses to start or finish homework	<input type="checkbox"/>	Conflict with siblings
<input type="checkbox"/>	Other:		

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:

<input type="checkbox"/>	Showing interest in others	<input type="checkbox"/>	Understanding social rules
<input type="checkbox"/>	Making friends	<input type="checkbox"/>	Getting along with adults
<input type="checkbox"/>	Keeping friends	<input type="checkbox"/>	Getting along with peers
<input type="checkbox"/>	Taking turns	<input type="checkbox"/>	Sharing and cooperating
<input type="checkbox"/>	Standing up for self	<input type="checkbox"/>	Dealing with changes in routine
<input type="checkbox"/>	Managing anger	<input type="checkbox"/>	Over-reacting to sights or noises
<input type="checkbox"/>	Being invited to play by other child	<input type="checkbox"/>	Over-reacting to touch, taste or smell
<input type="checkbox"/>	Insisting on routines	<input type="checkbox"/>	Insisting on following rules
<input type="checkbox"/>	Engaging in "give and take" conversations	<input type="checkbox"/>	Other:

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):
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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:

<input type="checkbox"/>	Repeated a grade	<input type="checkbox"/>	Failed courses at school
<input type="checkbox"/>	Attended/attends French Immersion Grades:	<input type="checkbox"/>	Attended school in language other than English and French
<input type="checkbox"/>	Received special placement/support	<input type="checkbox"/>	Was often in trouble
<input type="checkbox"/>	Received special accommodation at school Ex: extra time/scribe for examinations, spellchecker, computer with word processing	<input type="checkbox"/>	Have been told this child has a learning disability/learning difficulties or an attention disorder
<input type="checkbox"/> 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	<input type="checkbox"/>					
Reading	<input type="checkbox"/>					
Spelling	<input type="checkbox"/>					
Math	<input type="checkbox"/>					
Written language output	<input type="checkbox"/>					
Artistic	<input type="checkbox"/>					
Athletic	<input type="checkbox"/>					

GENERAL

Relationship with teacher	<input type="checkbox"/>					
Relationship with peers	<input type="checkbox"/>					
Bullying by peers	<input type="checkbox"/>					
Motivation	<input type="checkbox"/>					
Enjoyment of school	<input type="checkbox"/>					
Study skills	<input type="checkbox"/>					
Memory	<input type="checkbox"/>					
Organization	<input type="checkbox"/>					

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.