Saskatchewan Health Authority

Return to: Children's Mental Health Services
715 Queen Street
Saskatoon, Saskatchewan S7K 4X4
Tel (306) 655-7800 / Fax (306) 655-7437
Email form to: MHASCHILDRENSTEAM@saskatoonhealthregion.ca

FAMILY INFORMATION FORM

CHILD'S LEGAL NAME (IN FULL):
(As on health card) *Last Name* *First* *Middle*
DATE OF BIRTH:

NAME OF PERSON COMPLETING THIS FORM:

RELATIONSHIP TO CHILD:

DATE:

Dear Parents:

The following information will help us to understand your child/family. Please fill in the blanks as thoroughly as possible. If you do not know an answer, you can write, "don't know". Feel free to make additional comments in the space on the last page.

What made you decide to seek help?

What changes would you like to see as a result of your contact here?

One problem may be related to or be influenced by another problem. Is your family experiencing any other problems at this time?

In the past year, has your child experience any serious upset, significant losses or death? If so, please explain.

FAMILY INFORMATION

☐ Parents together

☐ Parents separated/divorced, if so please provide information:

Parents/Guardians living with child

Name: Relationship to child:

Age: Occupation:

Name: Relationship to child:

Age: Occupation:

Parents/Guardians living apart from child

Name: Relationship to child:

Age: Occupation:

Address: Contact Number:

Name: Relationship to child:

Age: Occupation:

Address: Contact Number:

List all the other persons (including other children) who presently live in your home

Name	Preferred Pronoun/ Identified Gender	Age	Relationship to Child	If child, is he/she natural, adopted, step or foster	Occupation/ Grade

Immediate family members NOT living in the home

Name	Preferred Pronoun/ Identified Gender	Age	Relationship to Child	If child, is he/she natural, adopted, step or foster	Occupation/ Grade

MEDICAL INFORMATION

Child's Medical History

Who is/are your child's family doctor/pediatrician/psychiatrist and their phone number/s?

Is your child on medication? **Yes** ☐ **No** ☐

If yes, what medication/s?

Has the child had any of the following recently?

	Yes	No	If yes, give details
Allergies	☐	☐	
Bedwetting	☐	☐	
Soiling	☐	☐	
Epilepsy, Convulsions, Seizures	☐	☐	
Intellectual Disability/Developmental Delay	☐	☐	
Chronic Pain	☐	☐	
Hearing Issues	☐	☐	
Vision Issues	☐	☐	
Learning Disabilities	☐	☐	
Physical Disabilities	☐	☐	
Hyperactivity/ Inattentiveness	☐	☐	
Speech Delays	☐	☐	
Trauma	☐	☐	

Mental health history of immediate family members

	Yes	No	Name/relation to child/details
Substance and alcohol abuse	☐	☐	
Family violence	☐	☐	
Chronic pain	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Suicide ideation/attempts	☐	☐	
Learning disabilities	☐	☐	
Trauma	☐	☐	

Any other mental health concerns

Has your child previously been involved with any community agencies for counseling? Yes ☐ No ☐

If so, please specify: type of service, name of agency and dates of service.

Has your child had any assessments completed (i.e., at Alvin Buckwold Child Development Centre/school and/or OT, SLP, PT, psychology or other)? Yes ☐ No ☐

If yes, please specify and provide copy/copies:

PRESCHOOL HISTORY

Has your child's behavior been of any concern at the pre-school or day-care? Yes ☐ No ☐

What have the concerns been?

Has your child ever been asked to leave a pre-school or day-care setting? Yes ☐ No ☐

What were the reasons given?

SCHOOL HISTORY

Name of present school:

Teacher: Grade:

Other Schools Attended	City/Town/Province	Year(s)	Grade(s)	Age (s)

School Progress:

Has your child had any particular difficulties with school? If yes, please specify:

Has your child received any special help in school? If yes, please describe:

Has your child's behavior been of any concern at school? Yes ☐ No ☐

If yes, please describe:

DEVELOPLMENTAL HISTORY

Pregnancy:

During the pregnancy, did the mother experience any illnesses, complications, or accidents?

Were any drugs (prescribed or non-prescribed) or alcohol taken during pregnancy?

Were there any problems with other pregnancies (miscarriage, difficult delivery)? Explain:

During the pregnancy, did either parent experience any emotional concerns or upsets? Please describe:

Delivery:

Duration of Pregnancy: Birth Weight:

Describe any difficulties with the delivery (e.g. Cesarean Section, medication required, breech birth, etc.)

What was the emotional experience of the parents concerning the delivery?

What were the reactions of other family members i.e. siblings to the new baby?

Did the mother experience any upset or depression during the first year of the child's life? How long?

Please describe:

Did the child have issues meeting developmental milestones (e.g. sitting up, talking, walking)?

Comment on what it was like to care for this child:

As an infant:

As a toddler:

General Information: (please specify yes or no and give explanation)

Was the child a cuddly infant or toddler?

Has the child had any problems with:

- eating or appetite?
- any particular fears?
- sleeping?
- discipline?

How does the child get along with other children?

How does the child get along with adults?

How active is the child?

How many homes has your child lived in?

Please indicate here any other information, which you feel, may be helpful for us to know: