Return to: Saskatoon Health Region
Mental Health and Addiction Services
Child & Youth Program
715 Queen Street
Saskatoon, Saskatchewan S7K 4X4
Tel (306) 655-7800/7802 / Fax (306) 655-7811

FAMILY INFORMATION FORM

CHILD'S LEGAL NAME (IN FULL): ______________________________
(As on health card) Last Name First Middle

DATE OF BIRTH: ______________________ HSN: ______________________
(mm/dd/yyyy)

ADDRESS: ______________________________
Street/Box Number City/Town Postal Code

PHONE NUMBER: Home ______________ Work ______________ (Father)
Work ______________ (Mother)

****

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.

In your words, please state the problems your child/family is experiencing or the reasons for your request for services. ______________________________

____

____

____

When did the problem first begin? ______________________________

____

____

____

Are there circumstances (past or present) in your family's life, which you connect with the current difficulties? ______________________________

____

____

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? ____
____

Has your child experienced any serious upset? ____
____

Has your child suffered any significant losses? ____
____

Has anyone close to this child died (including pets)? ____
____

FAMILY INFORMATION

Parents living with child

Father (Step__) _________________________ Age ________ Occupation _____________________

Mother (Step__) ________________________ Age ________ Occupation _____________________

Parents living apart from child

Father (Step__) _________________________ Age ________ Occupation _____________________

Address __________________________________ Telephone ______________________________

Mother (Step__) ________________________ Age ________ Occupation _____________________

Address __________________________________ Telephone ______________________________

Date of current union/marriage ____

Any previous marriages/common-law unions? Yes ☐ No ☐

If yes, please list dates of unions and separations; names of spouses and whereabouts; names, ages and whereabouts of children from these unions.

Is there contact with the parent who is not with the child? If so, how often? _______________________
____
____

When Parents are living separately:

Date of Separation/Divorce: ________________________________

Full (sole) Custody ☐ → Permanent ☐ or Interim ☐

Joint Custody ☐ → Permanent ☐ or Interim ☐

No Legal Order ☐

Do you expect an agreement soon? ____

____

____

Foster Parents/Guardians

Father ______________________________Age ________Occupation ____________________

Mother _____________________________Age ________Occupation ____________________

Address ___________________________________Telephone __________________________

Location of Department of Community Resources and Employment Office (DCRE, formerly DSS)

____

Name of Child Care Worker ____

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

Name	Sex	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	Sex	Age	Relationship to Child	If child, is he/she natural, adopted, step or foster	Occupation /Grade

MEDICAL INFORMATION

Child's Medical History

Is your child on medication? Yes ☐ No ☐ What medication? ______________________

____

Has your child ever had any of the following?

Ear Infection Yes ☐ No ☐

Visual Problems Yes ☐ No ☐

Hearing Problems Yes ☐ No ☐

Speech Problems Yes ☐ No ☐

Allergies Yes ☐ No ☐

Seizures Yes ☐ No ☐

High Fever Yes ☐ No ☐

Broken Bones Yes ☐ No ☐

Soiling Yes ☐ No ☐

Bedwetting Yes ☐ No ☐

Head Injury Yes ☐ No ☐

Problems with Balance/Coordination Yes ☐ No ☐

Problems with Diet Yes ☐ No ☐

Problems with Weight Loss Yes ☐ No ☐

Other Serious Infections Yes ☐ No ☐

List any illnesses or injuries for which the child required hospitalization and/or surgical operations:

Illness Doctor Date Hospital

____

____

Family Medical History

Have any members of your family (state relationship of child) had any of the following problems?

	Yes	No	If yes, give details
Allergies	☐	☐	________________
Bedwetting	☐	☐	________________
Soiling	☐	☐	________________
Epilepsy, Convulsions, Seizures	☐	☐	________________
Mental Retardation	☐	☐	________________
Emotional Problems	☐	☐	________________
Alcohol/Drug Problems	☐	☐	________________
Chronic Pain Problems	☐	☐	________________
Hearing Problems	☐	☐	________________
Sight Problems	☐	☐	________________
Learning Problems	☐	☐	________________
Physical Disability	☐	☐	________________
Hyperactivity	☐	☐	________________
Speech Problems	☐	☐	________________
Suicide	☐	☐	________________
Family Violence	☐	☐	________________

Others? Describe: ____

Is any member of the family currently ill? ☐ ☐ ________________

Explain:____

Are any members of the family taking medications at the present time (e.g. thyroid medicine, Tranquilizers, etc.)? ☐ ☐ ________________

Explain: ____

Have any family members previously been involved with any community agencies, or any other type of counseling? ☐ ☐ ________________

If so, please specify: ____

Who is receiving the service? What kind of service? With what agency? Date of service:

____

____

____

PRESCHOOL HISTORY (Complete if child is age 12 or under)

(Please include below Name of Program, Child's Age(s), and for how long attended:)

List any pre-school programs your child has attended: ___________________________________

List any day-care centres your child has attended: ____________________________________

Has your child been cared for in a family day-care home? Yes ☐ No ☐

For how long? ____

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)

Has your child had any frequent absences from school or been absent for more than one month? _______

If yes, specify: ____

____

____

School Progress:

Has your child had any particular difficulties with school work? 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: ____

____

____

____

Child and Youth is one of the programs of Mental Health and Addiction Services, Saskatoon Health Region, located at the following three different sites.

715 Queen Street, Saskatoon, SK S7K 4X4

Room 241, Ellis Hall, Royal University Hospital, Saskatoon, SK S7N 0W8

311 - 20th Street East, Saskatoon, SK S7K 0A9 (Youth Resource Centre)

To ensure that your child/youth receives the best possible service, it may be necessary from time to time, to communicate across sites on your behalf, both verbally and in writing to other professional mental health staff. All information will remain in confidence within the Child and Youth Program.

Signed: ____

Relationship to Child: ____

Date: ____

APPENDIX - DEVELOPLMENTAL HISTORY

Pregnancy:

During the pregnancy, did the mother experience any illness, condition or accident (German Measles, RH incompatibility, false labor, etc.)? ____

____

____

Were any drugs (prescribed or non-prescribed), alcohol or tobacco 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: ___________Duration of Labour ______________Birth Weight _____________

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

____

____

Following birth, did the infant have trouble starting to breathe?___________________________________

Describe anything unusual at birth or in the first few weeks of life (jaundice, infection, convulsions, etc.)?

____

____

What was the emotional experience of the mother concerning the delivery?_________________________

____

What was the emotional experience of the father concerning the delivery?__________________________

____

What were the reactions of other family members to the new baby? ______________________________

____

Development:

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

Please describe: ____

____

How old was the child when he/she: smiled ______sat without support ________

Walked without support __________ used single words (other than mama or dada) ___________

Combined two words into simple phrases (e.g. more juice, fall down) __________

Spoke in short sentences __________ was bladder trained (day)_________ (night) ____________

Was bowel trained (day) __________ (night) ____________ stood _______

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)

As an infant, did the child have any difficulty sucking, chewing or swallowing? _____________________

____

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? ____

Has the family moved since the birth of this child? Yes __________No _________

In how many homes has the child lived? ____

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

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____

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