SASKATOON HEALTH REGION
Saskatoon, Saskatchewan
Mental Health & Addiction Services
Child and Youth Program

NAME:

HSN:

FAMILY INFORMATION FORM

DOB: (dd/mm/yyyy)

(**For Office Use Only)**

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. _____

_____

_____

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

_____

_____

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

_____

FAMILY INFORMATION

Parents/Foster Parents/Caregiver living with child

Father (Step)_____Age _____Occupation _____

Mother (Step)_____Age _____Occupation _____

*Name of Child Care/Family worker if child is in the care of the Ministry of Social Services:

_____

Parents living apart from child
Father (Step__)_____Age _____Occupation _____
Address _____ Telephone _____
Mother (Step__)_____Age _____Occupation _____
Address _____ Telephone _____
Date of current union/marriage _____

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? _____

Child's Medical History

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

_____

Are any family members presently involved with any community agencies, or any other type of counseling? ☐ ☐ _____

If so, please specify: _____

SCHOOL HISTORY

Name of present school: _____

Teacher: _____ Grade: _____

School Progress:

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

_____

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

If yes, please describe: _____

_____

Return to:

Saskatoon Health Region

Mental Health & Addiction Services

Child and Youth Program

715 Queen Street

Saskatoon, Saskatchewan S7K 4X4 Telephone (306) 655-7800/7802 / Fax (306) 655-7811

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: _____