



WELCOME TO INFINITY PEDIATRICS!

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To help us make the most of our initial meeting together, we ask that you complete the following questionnaire **before** your first appointment. This will provide us with some background on your concerns along with giving us an overview of the past medical history and some information about your family.

The questionnaire is from the Canadian Pediatric Society (whom also have a great general health page for parents www.caringforkids.cps.ca). Since it is meant to cover from birth to 18 years of age, some of the questions may not be applicable.

Once you complete the questionnaire, please email (with email consent), fax, mail or drop off **before** the appointment, so that the pediatrician has time to review it in advance.

Thank-you for taking the time to provide us with this information! We are looking forward to meeting your family!

Sincerely,

The Pediatricians at Infinity Pediatrics

PARENT QUESTIONNAIRE

A. General Information

Child's name:

☐ Male ☐ Female

Name at birth if different from above:

Resident Address:

City/Town/Village:

Province/Territory:

Postal code:

Child's date of birth (yy/mm/dd):

Age:

Provincial health care insurance number:

Is the child a Registered First Nations?

☐ Yes ☐ No

Please attach a recent
photograph of your child.
(OPTIONAL)

Parents/Legal Guardians:

Name:

Name:

Address: ☐ Same as child; or:

Address: ☐ Same as child; or:

No./street:

No./street:

City:

Prov/Terr:

City:

Prov/Terr:

Phone: (H)

(W)

(C)

Phone: (H)

(W)

(C)

☐ Biological

☐ Adoptive

☐ Foster

☐ Biological

☐ Adoptive

☐ Foster

☐ Step-parent

☐ Grandparent

☐ Step-parent

☐ Grandparent

Language(s) spoken at home: 1.

2.

If English is not spoken at home, indicate the name of an English-speaking contact person:

Phone: (H)

(W)

(C)

List everyone living in the home:



Child's guardianship status (if applicable): _____

Social worker/legal guardian (if applicable): _____

Address: _____ Phone: _____ Fax: _____

Who suggested this referral? _____

Family physician: _____ Paediatrician: _____

Please list your main concerns:

Do you have any specific questions you would like answered?

Current daycare/preschool/school: _____ Grade/level: _____

Contact name and title/role: _____ Phone: _____

List the preschools, daycare centres, and schools your child has attended. Use a separate sheet if necessary:

Name of program/school	Years attended	Grade/level	Problems noted	Special programs

Previous assessments:

	Date	Consultant or agency	Is your child currently involved?
Psychology			
Speech-language pathology			
Occupational/physiotherapy			
Audiology (hearing)			
Vision			
Other:			

PLEASE ATTACH ANY AVAILABLE REPORTS OF PREVIOUS ASSESSMENTS TO THIS QUESTIONNAIRE.



Are you aware of any assessments planned in the next six to twelve months? Yes ☐ No ☐

If yes, when, where, and by whom? _____

B. Prenatal/Birth History - Please provide information for child being seen ONLY

Total number of pregnancies: _____ Any miscarriage(s)/stillbirth(s)/abortion(s): _____

Duration of this pregnancy (weeks): _____

Did you have any of the following during this pregnancy?

Check all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Excessive vomiting | <input type="checkbox"/> Operation(s) | <input type="checkbox"/> Excessive vaginal bleeding |
| <input type="checkbox"/> Infection with fever or rash | <input type="checkbox"/> Injuries/accidents | <input type="checkbox"/> Gestational Diabetes |
| <input type="checkbox"/> Toxemia (high blood pressure) | <input type="checkbox"/> Unusual emotional stress | _____ |
| <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Prolonged hospitalization(s) | _____ |

During your pregnancy, did you:

Smoke cigarettes? ☐ No ☐ Less than ½ pack per day ☐ ½ to 1 pack per day
☐ More than 1 pack per day

Drink alcoholic beverages? ☐ No ☐ First three months only ☐ Throughout most of pregnancy

Amount each time (1 drink = 1 beer, 1 glass of wine, or 1 mixed drink):

☐ 1–2 drinks ☐ 3–5 drinks ☐ 6 drinks or more

Frequency: ☐ Once per week ☐ Two or more times per week

Use prescription or nonprescription medications? ☐ No ☐ Yes

Use any drugs (marijuana, cocaine, heroin, etc.)? ☐ No ☐ Yes

Name of birth hospital: _____ City/Province: _____

How long was labour? _____ hours Was labour: ☐ Spontaneous? ☐ Induced?

Birth Weight: _____ kg



Type of anaesthetics: ☐ General ☐ Spinal ☐ Local ☐ None ☐ Other

Method of delivery: ☐ Spontaneous ☐ Assisted (forceps used) ☐ Vacuum extraction
☐ Vaginal ☐ Caesarean (elective) ☐ Caesarean (emergency)

Position of baby: ☐ Head first ☐ Breech ☐ Other

Were there any concerns about your baby (such as fetal distress) immediately before the birth?

☐ No ☐ Yes Please explain: _____

Did your baby need any help to breathe right after birth?

☐ No ☐ Yes Please explain: _____

How was your baby fed? Were there any feeding problems? _____

Did your baby have any of these problems at birth or during the first month of life? Check all that apply?

- | | | |
|---|--|--|
| <input type="checkbox"/> Poor sucking | <input type="checkbox"/> Injured at birth | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Unusual rash | <input type="checkbox"/> Trouble breathing | <input type="checkbox"/> Was given medications |
| <input type="checkbox"/> Turned yellow | <input type="checkbox"/> Turned blue | <input type="checkbox"/> Infection (specify) _____ |
| <input type="checkbox"/> Received blood transfusion | <input type="checkbox"/> Kept in incubator (how long? _____) | <input type="checkbox"/> Seizures/convulsions |
| <input type="checkbox"/> Needed surgery | <input type="checkbox"/> Transferred to intensive care nursery | <input type="checkbox"/> Was very jittery |
| <input type="checkbox"/> Other problems: _____ | | |



C. Child's Developmental and Medical History

Early development: When (specify age in years and months, if possible) did your child first accomplish the following:

Age	Milestone	Age	Milestone	Age	Milestone
	Sat without help		Crawled		Walked alone for 10 to 15 steps
	Toilet trained (day)		Toilet trained (night)		Walked upstairs
	Rode a bike without training wheels		Used sentences		Used a spoon
	Spoke first words ("mama," "dada")		Rode a tricycle using pedals		Named 3 or more colours
	Ate independently		Counted from 1 to 10		Named 3 or more body parts
	Used fingers to feed		Put 2 or 3 words together		

When did you first become concerned about your child's development? _____

Do you have any concerns now? _____

Has your child lost any skills he or she used to be able to do? _____

Functional problems: Please check which, if any, of the following concerns you have:

- | | | |
|--|--|---|
| <input type="checkbox"/> Feeding difficulties | <input type="checkbox"/> Withdrawn/In own world | <input type="checkbox"/> Unusual/Odd mannerisms |
| <input type="checkbox"/> Avoiding eye contact | <input type="checkbox"/> Clumsy/Awkward/Poorly coordinated | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Limited food choices | <input type="checkbox"/> Recurrent stomach ache | <input type="checkbox"/> Unusual fears/Anxiety |
| <input type="checkbox"/> Social skill difficulties | <input type="checkbox"/> Resistance to change of routine | <input type="checkbox"/> Trouble falling asleep |
| <input type="checkbox"/> Soiling | <input type="checkbox"/> Night crying/Nightmares | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Shy with strangers | <input type="checkbox"/> Snoring | <input type="checkbox"/> Rocking/Head banging |
| <input type="checkbox"/> Recurrent headaches | <input type="checkbox"/> Hyperactive/Impulsive | <input type="checkbox"/> Aggression toward self or others |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Defiant/Negativistic | <input type="checkbox"/> Cruelty to animals |
| <input type="checkbox"/> Destructive to property | <input type="checkbox"/> Stealing | <input type="checkbox"/> Setting fires |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Inappropriate sexual behaviour | <input type="checkbox"/> Thumb-sucking/Nail-biting |
| <input type="checkbox"/> Frequent temper tantrums | <input type="checkbox"/> Resistance to going to school | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Trouble with police | | |

Discipline: When your child is misbehaving, what do you usually do?



Past health problems: Please give age of occurrence and details.

- | | | |
|---|---|--|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Hearing problem | <input type="checkbox"/> Tics or muscle twitches |
| <input type="checkbox"/> Rash/Skin problems | <input type="checkbox"/> Eye problem | <input type="checkbox"/> Casts/Braces |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Recurrent infections | <input type="checkbox"/> Surgery (operations) |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Admissions to hospital |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other (specify): _____ |

Details: _____

List any long-term medication, special diets, or large doses of vitamins (taken for longer than two weeks at a time)?

Name/dose: _____ When: _____

Name/dose: _____ When: _____

Name/dose: _____ When: _____

Immunization up to date?

Yes No

Allergies?

Yes No

If yes please describe: _____

Birth parent information/Family history:

Birth mother

Name: _____

Age: _____

Present occupation: _____

Education (highest grade completed): _____

Any learning/behaviour/

emotional problems? _____

Any health problems? _____

Birth father

Name: _____

Age: _____

Present occupation: _____

Education (highest grade completed): _____

Any learning/behaviour/

emotional problems: _____

Any health problems? _____

Marital status: _____ Are the birth mother and father related? ☐ Yes ☐ No

Describe special circumstance (e.g., other parental relationships involved): _____



Siblings:

Full Name	Age	Gender (M/F)	Grade	Relationship (full, step, half)	Health, learning or behaviour problems

Health conditions in the family: (Ex. Mom, Dad, Brother, Grandma etc.)

Check conditions that apply and indicate relationship to your child.

Problem/Condition	Relationship to child	Problem/Condition	Relationship to child
ADHD		Migraine headaches	
Behaviour problems in childhood		Epilepsy	
Learning, reading problems		Autism spectrum disorder	
Speech problems		Thyroid problems	
Developmental delay		Depression	
Repeated a grade		Anxiety disorder	
Genetic syndrome/birth defect		Drinking problems	
Vision problems		Drug abuse	
Hearing problems		Other mental health issues	
Cerebral palsy		Other: _____	

Have there been any major events that may have been stressful to the family (e.g., moving home, physical/mental illness, death, separation/divorce, unemployment, legal or financial problem)?

Additional information that you feel may help us better understand your child (e.g., additional school history):

Name of person filling out this form: _____

Signature: _____ Date: _____

