



INFINITY
PEDIATRICS

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WELCOME TO INFINITY PEDIATRICS!

You have received this form, as we will be seeing this child for questions around developmental/learning/behavioural difficulties. As the child's preschool teacher, we are asking for some additional info, so that we can make the most of our first appointment with the family.

The following questionnaire is from the Canadian Pediatric Society. Since it is meant to provide information on a variety of concerns, some of the questions may not be applicable. Furthermore, if you have any speech/physiotherapy/occupational therapy assessments, etc, please send them to us. If you feel that the questions do not adequately capture the concerns for this child, feel free to attach a letter with your concerns or call our office to book a phone appointment with the pediatrician.

Once you complete the questionnaire, please give back to the family (or if the family prefers email/fax/mail directly to us), as the family will be required to provide us with school information **before** the appointment is booked.

Thank-you in advance for providing us with this very useful information!

Sincerely,
The Pediatricians at Infinity Pediatrics

PRESCHOOL/KINDERGARTEN QUESTIONNAIRE

Child's name: _____ Birth date: _____

Parent/Guardian: _____

To the teacher: Your careful completion of this questionnaire, which will help us to assess this child's needs, is greatly appreciated. Please return to: _____

Name of preschool/kindergarten: _____ Contact name: _____

Address: _____ City/province: _____ Postal code: _____

Phone: _____ Fax: _____

Type of program

<input type="checkbox"/>	Nursery school/preschool	<input type="checkbox"/>	Half-day	<input type="checkbox"/>	Regular
<input type="checkbox"/>	Kindergarten	<input type="checkbox"/>	Full-day	<input type="checkbox"/>	Special needs

Date child was enrolled: _____ Who initiated this referral? _____

Please list any specific questions or concerns for which you would like help:

What are the child's greatest strengths?

What are the child's weaknesses or difficulties?

Describe the child's learning style (activity level, organizational skills, impulsiveness, etc.):

Describe the child's behaviour:

Describe the child's peer relationships and social interaction skills:

Which of the following resources are available to your school?

Professional	Consultant or agency	Is this child currently involved?
Special education teacher		
Special education assistant/aide		
Special education program		
Speech-language therapy		
Physiotherapy		
Occupational therapy		
Psychologist		
Community health nurse		
Social worker		
Other (specify)		

Please assess the child in the following areas:

Skill set	Major concern	Minor concern	No concern	Cannot judge	Comments
Gross motor skills					
Posture					
Awkward gait					
Frequently falls					
Easily fatigued					
Tip-toe walking					

Skill set	Major concern	Minor concern	No concern	Cannot judge	Comments
Gross motor skills (cont'd)					
Ball skills					
Playground skills					
Playground safety					
Coordination					
Other (specify)					
Fine motor skills					
Crayon/pencil skills					
Use of scissors					
Easily fatigued when printing					
Hand dominance (switching hands)					
Puzzle skills					
Other (specify)					
Self-help skills					
Undressing self					
Dressing self					
Use of zippers/buttons					
Feeding self					
Washing hands/face					
Helping clean up					
Toileting routines					
Toileting accidents/soiling					
Other (specify)					
Social skills					
Interest in peers					
Initiation of interactions with peers					
Social responses to peers					
Group play with peers					
Imaginative play					
Solitary play					
Repetitive motor movements or behaviours (spinning, flapping, tics)					
Ability to share					
Turn-taking					



Skill set	Major concern	Minor concern	No concern	Cannot judge	Comments
Offering comfort					
Compliance with rules and limits					
Adjustment to new or changed routines					
Behaviour					
Attention span					
Impulsivity					
Hyperactivity or motor restlessness					
Physical aggression					
Destructive tendencies					
Temper tantrums					
Breath-holding spells					
Unusual fears					
Obsessive interests/ topics					
Ritual behaviours					
Phobias					
Somatic complaints (stomach aches, headaches, pains)					
Difficult temperament/ moods					
Other (specify)					
Receptive language skills					
Following 1-step instructions					
Following 2-step instructions					
Listening in a group					
Listening to stories					
Listening to rhymes and tunes					
Other (specify)					
Expressive language					
Pronunciation					
Speaking in phrases/ sentences					
Taking turns in conversation					

Skill set	Major concern	Minor concern	No concern	Cannot judge	Comments
<i>Expressive language (cont'd)</i>					
Effective verbal communication					
Stuttering					
Other (specify)					
<i>Academic readiness skills</i>					
Knowledge of sizes/shapes					
Knowledge of colours					
Letter recognition					
Number recognition					
Rote count 1 to 10					
Knowledge of number concepts					
Ability to read and print first name					
Other (specify)					

Has there been a deterioration, loss, or plateauing of previously acquired skills in the past year?

No Yes (specify:) _____

General comments: _____

Name of person filling out this form: _____ Title: _____

Signature: _____ Date: _____

Please attach copies of the child's latest assessment or progress reports and include any other information that might help in assessment of this child.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

