FAMILY INFORMATION FORM

Personal and Confidential

PERSONAL INFORMATION – REQUIRED BY SASKATCHEWAN HEALTH							
CHILD'S LEGAL NAME:						DOB:	DD/MM/YYYY
	Last		First		Middle		
				Child's Personal Health #			
Mother's name (as on health card)		DOB	DD/MM/YYY	Mother's Personal Health #			
father's name (as on health card)		DOB	DD/MM/YYYY	Father's Personal Health #			

CONTACT INFORMATION			
Child's Home Address:		Guardian's Address and Phone Number (if different from Child's)	
		Phone Number:	
Home Phone Number:		Name of Child's Primary Contact or Legal Guardian:	
Mother"s Contact #	(work)	(cell)	(other)
Father's Contact #	(work)	(cell)	(other)
_____ Contact #	(work)	(cell)	(other)

FAMILY INFORMATION					
Family living with child					
Father:	Age:	Occupation:			
Mother:	Age:	Occupation:			
	Age	Occupation / Grade:			
	Age	Occupation / Grade:			
	Age	Occupation / Grade:			
	Age	Occupation / Grade:			
Family living apart from child					
Father:	Age:	Occupation:	In contact? Yes □ No □		
Mother:	Age:	Occupation:	In contact? Yes □ No □		
Please Describe Contact / visiting arrangementS					
Is the Department of Child and Family Services involved with your family?	Yes □	No □	CFS Worker\s Name and Contact #		

In your own words, what are your concerns about your child? When did it start?

MEDICAL HISTORY			
Does your child take medications?	Yes □	No □	If Yes, Please Provide Details:
Does your child have any allergies?	Yes □	No □	
Does your child have any health problems currently?	Yes □	No □	
Has your child ever experienced a head injury, loss of consciousness, or seizure?	Yes □	No □	
Does your child have any chronic medical problems?	Yes □	No □	
Does your child have a history of any serious injuries or medical hospitalizations?	Yes □	No □	
Has your child ever had any surgeries?	Yes □	No □	
Does your child have chronic pain (frequent headaches, stomach aches, chest pain)?	Yes □	No □	
Has your child ever had an EEG, MRI, CT SCAN, etc?	Yes □	No □	

MEDICATIONS		
List all medications	Dose and duration of use	Was it effective?

MENTAL HEALTH HISTORY				
Has your child a history of or been treated for any of the following?				If yes, please provide details.
□ PTSD	□ Anorexia/Bulimia	□ Drug Problems		
□ Panic Attacks	□ Bing-eating	□ Schizophrenia		
□ OCD	□ Alcohol Problems (including AA)	□ Bipolar (Manic/Depressive) Disorder		
□ behavior problems	□ self-harm or suicide attempt	□ Psychiatric Hospital Stay		
Has your child been involved or received services from the following?				
Child Protective Services	Yes □ No □	Speech and language therapy	Yes □ No □	
Probation/Legal Problems	Yes □ No □	Early Intervention Services (ages 0-3)	Yes □ No □	
Mental Health Services	Yes □ No □	Counsellors or Psychologists (list names)	Yes □ No □	
Has your child seen a psychiatrist in the past? **Yes** □ **No** □				
Please provide names and age at which child was seen.				

FAMILY HISTORY

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent		
Depression										
Anxiety										
Panic Attacks										
Post-Traumatic Stress										
Bipolar / Manic Depression										
Schizophrenia										
Alcohol Problems										
Drug Problems										
ADHD										
Suicide Attempts										
Psychiatric Hospital Stay										

Other history not included above:

Developmental and Academic History

Current grade level:	Current School:
What are your child's academic strengths?	
What are your child's academic weaknesses?	
Has there been a change in your child's performance at school?	If 'Yes', please describe.
Yes □ No □	

Has your child received IQ or Academic testing?	If 'Yes', where was it done?
Yes □ No □	

Does or has your child participated in any of the following?	Has Your Child struggled with the following?
□ Resource	□Truancy, explain:
□ Accelerated or Honors programs	□ Fights, explain:
□ Online classes	□ Absenteeism, explain:
□ Home schooling	□ Suspension, explain:
Additional info:	□ School refusal, explain:

Social History

Are there any stressors or struggles your family is currently facing? **Yes □ No □ If Yes please describe.**	Has your child ever been the victim of abuse or neglect? Yes □ No □ If yes, check all that apply.		
	□ Physical	□ Emotional	□ Neglect
	□ Accidents	□ Disasters	□ Sexual
	□ Witnessing Violence	□ Other:	
Are you struggling with your marital relationship or parenting? If yes please explain:	Has your child ever been bullied? Yes □ No □		
Are you concerned regarding your adolescent's friendships?	Has your child ever bullied other children? Yes □ No □		
Are you concerned that your adolescent is using (or has used) drugs (including over the counter medicines) or alcohol? If 'Yes', please explain:	Are you concerned about high risk behavior (sexual activity, speeding, self-harm, suicide)? If 'Yes', please explain:		