A comprehensive history allows us to make the most informed clinical decisions for your child. We want to tailor our services to your child's specific needs. We have a strong interdisciplinary focus: we want to get a picture of the whole child, as we recognize that functioning in one domain is affected by factors in all domains of a child's life.

Intake Questionnaire

A Client Information

Client Name:
(Last) (First) (Middle Initial)

Date of Birth: (Day) / (Month) / (Year)
Age:
Gender:

Street Address:

City:
Province:
Postal Code:
P.O. Box:
Home Phone No.:
Cell Phone No.:

Reason for Visit:

How Did You Hear About Boomerang Health?

Primary Language Spoken at Home:
Primary Language of Guardian(s):

Referral Name (Doctor, School, Therapist):
Referral Occupation:
Referral Phone/Address (If known):

School Name:

Primary Care Physician Name (If different from referral):
Primary Care Physician Number and Address:

B Family Information

Guardian Name:	**Guardian Name:**
Relationship to Child:	**Relationship to Child:**
Home Phone No.:	**Home Phone No.:**
Work Phone No.:	**Work Phone No.:**
Cell Phone No.:	**Cell Phone No.:**
Occupation:	**Occupation:**
Email:	**Email:**

Intake Questionnaire

B

Family Information (Continued)

1. With Whom Does Your Child Live?

2. Are There Any Custody/Access Issues?

3. Country of Origin:

4. How Long Has Your Child Lived in Canada?

5. If English is a Second Language, How Long Has Your Child been Speaking/Learning?

6. List of Other Individuals Living in Your Child's Household:

Name: Gender: Age:
Relationship:

Name: Gender: Age:
Relationship:

Name: Gender: Age:
Relationship:

Name: Gender: Age:
Relationship:

Name: Gender: Age:
Relationship:

Name: Gender: Age:
Relationship:

Intake Questionnaire

B

Family Information (Continued)

7. Please Check All Events that May Have Occurred Within the Immediate Family in the Past 12 Months:

- ☐ Divorce
- ☐ Significant Marital Conficts
- ☐ Pregnancy
- ☐ Gain of New Family Member
- ☐ Death of Close Family Member
- ☐ Personal or Family Injury or Illness
- ☐ Emotional/Psychological Stress (Parent)
- ☐ Change in Financial Status
- ☐ Legal Problems
- ☐ Violence in Neighbourhood
- ☐ Other: _____
- ☐ Parents Separation
- ☐ Marriage or Re-marriage
- ☐ Birth of Sibling
- ☐ Child Leaving Home
- ☐ Death of Close Friend
- ☐ Hospitalization of Family Member
- ☐ Change in Schools
- ☐ Change in Residence
- ☐ Loss of Employment
- ☐ Change of Custody/Guardian

8. Please Describe Any Relevant Family History Below:
(Developmental or physical disabilities, mental health, learning, communicaiton disorders)

C

Your Child's Particulars

1. What are the Specific Concerns that Brought You and Your Child to Boomerang Health?

2. Has Your Child Ever Received a Diagnosis? ☐ Yes ☐ No

If Yes, Please Provide:

3. Describe Your Child. What Does He/She Do Well? What are His/Her Preferred Activities and Interests?

Intake Questionnaire

D

Medical History

1. Please List Any Allergies Your Child Currently Has:

2. Do you Have Any Concerns With Your Child's Hearing? ☐ Yes ☐ No

3. Does Your Child Have a History of Any of the Following?

- ☐ Hearing Loss
- ☐ Tubes
- ☐ Frequent Ear Infections
- ☐ Hearing Aids
- ☐ None of the Above
- ☐ Other:

4. Has Your Child Had a Recent Hearing Test? ☐ Yes ☐ No

If Yes, Please Provide:

Date:

Location:

Results:

5. Do You Have Any Concerns With Your Child's Vision? ☐ Yes ☐ No

6. Does Your Child Wear Corrective Lenses? ☐ Yes ☐ No

7. Has Your Child Had a Recent Vision Test? ☐ Yes ☐ No

If Yes, Please Provide:

Date:

Location:

Results:

8. Does your Child Have a History of Any of the Following:

- ☐ Convulsions/Seizures
- ☐ Head Injury
- ☐ High Fevers
- ☐ Bronchitis/Pneumonia
- ☐ Sleep Problems
- ☐ Gastroesophageal/Gastrointestinal Reflux Disorder (GERD)
- ☐ Meningitis
- ☐ Encephalitis
- ☐ Muscle Pain. Specify _____
- ☐ Headaches
- ☐ Loss of Consciousness
- ☐ Stomach Aches
- ☐ Asthma
- ☐ Broken Bones
- ☐ Abnormalities of Muscle Tone
- ☐ Shortness of Breath
- ☐ Dizziness with Physical Exertion
- ☐ Activity Limitation Due to Heart Condition
- ☐ Feeding Difficulties
- ☐ Other:

Intake Questionnaire

D

Medical History (Continued)

9. Please List Any Medications Your Child is Currently Taking:

10. Please List Any Operations Your Child Has Had to Date:

Age	Operation

11. Is Your Child Involved with Other Services at Boomerang Health or Elsewhere? (Check all that apply)

Service	Previously	Currently	Waiting List	Location
Speech Language Therapy	☐	☐	☐	
Psychology	☐	☐	☐	
Physiotherapy	☐	☐	☐	
Occupational Therapy	☐	☐	☐	
Behavioural Therapy	☐	☐	☐	
Infant Development Worker	☐	☐	☐	
Resource Teacher	☐	☐	☐	
Developmental Assessment	☐	☐	☐	
Neurology	☐	☐	☐	
Genetics	☐	☐	☐	
Social Work	☐	☐	☐	

E

Pregnancy

1. Please Describe Mother's Pregnancy ☐ Normal ☐ Complications

2. If Any Complications Experienced During Pregnancy, Please Describe:

3. Length of Pregnancy:

☐ Normal (36–42 weeks gestation)
☐ Premature (Less than 36 weeks) Weeks:
☐ Overdue (Longer than 42 weeks) Weeks:

Intake Questionnaire

E

Pregnancy (Continued)

4. Delivery:

- ☐ Normal
- ☐ Breech
- ☐ Caesarian

Please Describe Any Complications During Delivery:

5. Baby's Birth Weight:

6. Did Your Child Require Any Additional Care After Birth (NICU, Surgery, etc.) ☐ Yes ☐ No

If Yes, Please Describe:

7. How Long was Your Child Hospitalized After Birth?

8. Please Identify Any Circumstances that Applied During Pregnancy and/or After the Your Child's:

- ☐ Concerns About Mood or Anxiety (Mother)
- ☐ Concerns About Mood or Anxiety (Father)
- ☐ Prenatal Exposure to Drugs/Alcohol
- ☐ Use of Medication for Health Condition (Mother)
- ☐ High Stress (Either Parent)
- ☐ Feeding Difficulties
- ☐ Concerns About Baby's Growth/Failure to Thrive
- ☐ Colic/Excessive Crying

If You Selected Any of the Above, Please Describe:

Intake Questionnaire

F

Developmental Details

1. Record the Approximate Age at Which Your Child Reached the Following Milestones:
(If You Cannot Recall or Your Child Has Not Yet Reached This Milestone, Indicate in the Comments)

Milestone	Age	Comment
Physical		
Sat Unsupported		
Crawled		
Stood Unsupported		
Walked Alone		
Independence		
Dressed Independently		
Toilet Trained Day		
Toilet Trained Night		
Independent with Toileting		
Language		
Babbled		
Spoke First Words		
Named Most Common Objects		
Combined Words (Want Cookie)		
Used Full Sentences		
Began to Read		

2. How Does Your Child Communicate:

- ☐ Non-Verbal Means
- ☐ Single Words
- ☐ Two-Word Combinations
- ☐ Short Phrases
- ☐ Full Sentences
- ☐ Other: _____

3. Do you Have Any Concerns About:

- ☐ Clarity of Speech
- ☐ Voice Quality
- ☐ Language
- ☐ Fluency/Stuttering

If You Selected Any of the Above, Please Comment:

_____

4. Does Your Child:

- ☐ Grind Teeth
- ☐ Have a Clumsy Walk/Struggle with Clumsiness
- ☐ Suck Thumb/Soother

Intake Questionnaire

F

Developmental Details (Continued)

5. Did Your Child Ever Develop His/Her Skills and Then Lose Them: ☐ Yes ☐ No

If Yes, Please Describe:

6. Does Your Child Have a Dominant Hand?

☐ Right ☐ Left ☐ No Dominance

7. Do You Have Any Concerns About Your Child's Play Skills and/or Social Skills?

☐ Yes ☐ No

If Yes, Please Describe:

8. What Happens if Someone Tries to Join His/Her Play? (Age 1 – 10)

9. With Whom Does He/She Play Best?

☐ Children of the Same Age
☐ Younger Children
☐ Older Children
☐ Adults

10. Does Your Child Have a Best Friend? ☐ Yes ☐ No

11. Does Your Child Play With a Wide Variety of Toys? ☐ Yes ☐ No

12. Do You Have Concerns About Any of the Following?

☐ Over-activity
☐ Impulsivity
☐ Defiance
☐ Depressed Mood
☐ Social Judgment
☐ Repetitive Behaviours
☐ Shyness
☐ Temper Tentrums
☐ Eating Behaviours
☐ Inattentiveness
☐ Aggression
☐ Anxiety
☐ Social Interaction Skills
☐ Bullying
☐ Mood Swings
☐ Obsessive Thoughts
☐ Self-Injurious Behaviour
☐ Other:

Intake Questionnaire

F

Developmental Details (Continued)

11. Please Describe Any Other Concerns About Your Child's Development or Behaviour:

G

School Story

1. Where does Your Child Go to School?

Name of School:

Name of Teacher:

Address:

Grade:

Telephone:

2. Does Your Child Require Any Additional Support/Accommodations in School?

☐ Yes ☐ No

If Yes, Please Describe:

3. Number of Hours Your Child Spends at Each Program During the Day (i.e. at School, Daycare etc):

4. What Extracurriculars Activities is Your Child Involved In?

5. Do You or Your Child's Teachers Have Any Concerns About Your Child's Learning?

☐ Yes ☐ No

If Yes, Please Describe:

Intake Questionnaire

H

Additional Advice

1. Is There Any Additional Information That You Feel Would be Helpful to Us?

Thank You for Taking the Time to Complete This Form