Dr. Gisele Ferguson
CHILD AND ADOLESCENT PSYCHIATRIST

_____
Name & Relationship to Child of Person Filling Out Form

Date form completed:_____

FAMILY INFORMATION FORM
Personal and Confidential

CHILD'S LEGAL NAME (in full)_____
(name as on BC Services Card) last name first middle

DATE of BIRTH: _____ Services Card Number: _____

ADDRESS: _____
Street/Box Number City/Town Postal Code

PHONE NUMBER: Home: _____

Alternate Contact #: Work: _____mother Cell: _____mother

Work: _____father Cell: _____father

Parent/Caregiver Names:_____

Services Card Number: **Mother:** _____ **Father**: _____
(names as on BC Services Card)

Date of Birth: Mother: _____ Father: _____

Dear Parents/Caregivers:

The following information will be helpful in improving our understanding of your child. Please fill in the blanks as thoughtfully as possible – do not leave blanks. If you do not know an answer, write "don't know".

In your words, what are your concerns about your child?

When did the problems first begin?

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

Has your child suffered any significant losses?

What made you decide to seek help?

What have you done to attempt to improve the problem?

What changes would you like to see as a result of your contact here?

FAMILY INFORMATION

Parents living **with** child:

Father (Step) _____ Age: _____ Occupation: _____

Mother (Step) _____ Age: _____ Occupation: _____

Date of current union/marriage: _____

Parents living **apart** from child:

Father (Step) _____ Age: _____ Occupation: _____

Address: _____ Telephone: _____

In contact with the child? Yes ☐ No ☐ If 'Yes', how often? _____

Mother (Step) _____ Age: _____ Occupation: _____

Address: _____ Telephone: _____

In contact with the child? Yes ☐ No ☐ If 'Yes', how often? _____

Foster parents/guardians:

Father: _____ Age: _____ Occupation: _____

Mother: _____ Age: _____ Occupation: _____

How long has the child been in your home? _____

Is MCFD involved with your family? Yes ☐ No ☐

If Yes, Worker's Name _____ Phone: _____

Worker's Office Address: _____

List all other persons (including other children) who presently live in your home.

Name	Sex	Age	Relationship to Child	If child: is he/she natural, adopted, step or foster?	Occupation or Grade

CHILD'S MEDICAL HISTORY

Is your child on medication? Yes ☐ No ☐

If 'Yes', what medication? _____

Does your child have any medication allergies? Yes ☐ No ☐

If 'Yes', please specify. _____

Is your child physically well? Yes ☐ No ☐

(or) Does your child have any health problems currently? Yes ☐ No ☐

If yes, please specify:

Has your child ever had any of the following?

	Yes	No			Yes	No
Allergies	☐	☐		Hearing problems	☐	☐
Bedwetting	☐	☐		Heart problems	☐	☐
Broken bones	☐	☐		Learning Problems	☐	☐
Clumsiness	☐	☐		Seizures	☐	☐
Ear infections	☐	☐		Soiling	☐	☐
Eating/Weight problems	☐	☐		Speech problems	☐	☐
Head injury	☐	☐		Visual problems	☐	☐

List any illnesses/injuries for which your child required hospitalisation and/or surgical operations.

Illness/Injury	Doctor	Date	Hospital

FAMILY MEDICAL HISTORY

Have any members of your family (state relationship to child) had any of the following problems?

	Yes	No	Who?			Yes	No	Who?
Alcohol/drug problems	☐	☐			Mood Disorder	☐	☐	
Anxiety	☐	☐			Schizophrenia	☐	☐	
Bedwetting	☐	☐			Seizures	☐	☐	
Family violence	☐	☐			Speech problems	☐	☐	
Hyperactivity	☐	☐			Soiling	☐	☐	
Learning problems	☐	☐			Suicide	☐	☐	
Intellectual Disability	☐	☐			Others?	☐	☐	

Is any member of the family currently ill?Yes ☐ No ☐ Don't know ☐

If 'Yes', please explain:

Are any members of the family taking medications at the present time?
Yes ☐ No ☐ Don't know ☐
If 'Yes', please explain:

DEVELOPMENTAL HISTORY

Pregnancy:
During the pregnancy, did the child's mother experience any illnesses, or accidents?

Were any drugs (prescription or non-prescription), alcohol, or tobacco taken during pregnancy?

Delivery:
Duration of pregnancy _____ Duration of labour _____ Birth weight _____

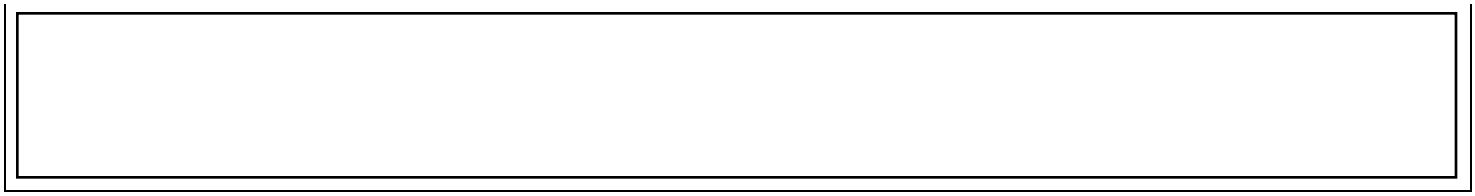
Describe any difficulties with the delivery (e.g. Caesarean Section, medication required, breech presentation etc.)

Following birth, did your child have trouble starting to breathe?

Was anything unusual at birth or in the first few weeks of life (jaundice, seizures etc.)?
Yes ☐ No ☐ If 'Yes', please specify:

Were developmental milestones like walking, talking, toilet training on track? Yes ☐ No ☐

If 'No', please specify:



PRESCHOOL HISTORY

List any pre-school programs and/or day care centres, or day homes your child has attended:

Name of Program	Child's Age	Length of time attended

Has your child's behaviour been of any concern at the pre-school, day care, or day home?
Yes ☐ No ☐ If 'Yes', what were the concerns?

SCHOOL HISTORY

Name of present school: _____ Grade: _____ Teacher: _____

Other schools attended	City/Town/Province	Year(s)	Grade(s)	Age

Has your child repeated a grade? Yes ☐ No ☐ If 'Yes', please specify:

Has your child had frequent absences from school or been absent for more than one month?
Yes ☐ No ☐ If 'Yes' please specify:

Has your child's behaviour been of any concern at elementary or high school?
Yes ☐ No ☐ If 'Yes', what were the concerns?

Child & Adolescent Psychiatry

Have any psychiatrists, agencies or counsellors been involved in your child's care?
Yes ☐ No ☐

If yes, please provide name(s) and date(s) of appointment(s):

Consent to Obtain and Release Information

To ensure that your child receives the best possible service, it may be necessary, from time to time, to communicate between offices on your behalf, both verbally and in writing, to other psychiatrists, physicians or professional mental health staff. All information obtained will remain confidential.

I give my consent for my child's psychiatrist to obtain and release information.

_____ _____

Patient's printed name *Patient's date of birth*

_____ _____

Signature of Parent or Legal Guardian *Parent/Legal Guardian's printed name*

_____

Date