Dr. Laura Thomson
Psychologists & Associates

Unit 1 - 1401 Plains Road, East, Burlington, ON L7R 0C2
Tel: 905-639-1199 • *Fax:* 905-633-7579 • *Email:* info@drthomson.ca
WWW.DRTHOMSON.CA

Date:

Referred By:

Child's Name [First]:

[Last]:

Date of Birth:

Present Age:

Present School:

Grade:

Name of Teacher:

Name of Principal:

FAMILY INFORMATION

Mother's Name [First]:

[Last]:

Address:

Home Phone:

Work Phone:

Cell Phone:

E-mail:

Occupation:

Email address for appointment reminders:

If parents are divorced what is the custody arrangement and visitation schedule:

Father's Name [First]:

[Last]:

Address:

Home Phone:

Work Phone:

Cell Phone:

E-mail:

Occupation:

Are both parents aware of and in agreement with treatment?

YES NO

Is litigation pending?

YES NO

If yes, describe:

SIBLINGS:

NAME	AGE

STEP SIBLINGS:

NAME	AGE

WHO LIVES WITH THE CHILD AT EACH PARENT'S HOUSE:

	NAME	RELATIONSHIP TO CHILD
MOM'S HOUSE		
DAD'S HOUSE		

Emergency contact person: Cell phone:

Home phone: Relationship to the child:

PHYSICAL HEALTH INFORMATION:

Family physician: Pediatrician:

Phone number: Psychiatrist:

Please list any significant medical problems that your child has had (and when):

Has your child ever had a concussion? (If so, please give details).

PLEASE LIST ALL MEDICATIONS THAT YOUR CHILD PRESENTLY TAKES:

MEDICATION	WHAT FOR?	DOSAGE

Please list any mental health medications (antidepressant, anti-anxiety, mood stabilizer, ADHD medications) that your child has taken in the past but no longer takes:

Please list any allergies:

Please specify any previous diagnostic information:

FAMILY HISTORY:

Is the child adopted?

◯ YES ◯ NO

If yes, describe the adoption history:

HAVE ANY OF YOUR CHILD'S BIOLOGICAL RELATIVES ON EITHER PARENT'S SIDE OF THE FAMILY HAD ANY OF THE FOLLOWING:

Condition or Event	Relationship to Child
Anxiety	
Panic Attacks	
Depression	
Obsessive-compulsive disorder	
Bipolar disorder	
Death from suicide	
Alcohol or drug problems	
Police record (arrests, jail)	
Schizophrenia	
Developmental delays	
Autism/ Asperger's	
Learning disorder	
Attention problems (ADHD)	
Tourette's or other tic problems	
Other (please describe)	

DEVELOPMENTAL HISTORY:

Pregnancy:

Complications for Mother:

Concerns about baby:

Drugs, alcohol, smoking during pregnancy:

Delivery:

Was the baby on time?

◯ YES ◯ NO

If early, how early:

If late, how late:

Mode of delivery (vaginal, c-section, spontaneous, induced, forceps, vacuum assistance):

Did baby require help after birth:

◯ YES ◯ NO

Birth weight:

Problems during first month of life:

Problems during first year of life:

Any postpartum mood difficulties:

Was your child slow in learning to roll, sit, climb, crawl or walk?

At what age did your child learn to walk:

Did your child have difficulty learning to ride a bike:

◯ YES ◯ NO

Do you think your child is unusually clumsy:

◯ YES ◯ NO

If yes, why:

Does your child have difficulty printing:

◯ YES ◯ NO

Has your child ever had an occupational therapist at school?

YES NO

Was it hard for your child to learn to use zippers, snaps, buttons or scissors?

YES NO

Did your child have a delay in learning how to talk?

YES NO

Has your child ever had speech therapy?

YES NO

Does your child make eye contact when speaking to you?

YES NO

Is your child able to make themselves understood by others?

YES NO

Is your child interested in social interactions?

YES NO

Does your child play with other children?

YES NO

Do you have any concerns about you child's social skills? What are these concerns?

Are there any concerns around sleep rountines? Describe:

Do you have to lie with your child until they fall asleep?

YES NO

How long does it take your child to fall asleep?

Does your child wake up in the night?

YES NO

Does your child sneak into your bed during the night?

YES NO

Does your child have frequent nightmares?

YES NO

Does your child sleep walk?

YES NO

Does your child have headaches?

YES NO

If yes, how often:

How are they treated:

SOCIAL HISTORY:

Have there been any major life events that may have been stressful for your child? (e.g. births, deaths, moving houses or schools, parents separating/divorcing, accidents, fires, loved ones with serious illnesses, trauma, bullying):

Does your child participate any extracurricular activities outside of school:

Do you think your child gets enough physical activity each week:

YES NO

SCHOOL ISSUES:

Is your child having any academic difficulties:

YES NO

If yes, please describe:

How much support does you child need to complete homework:

Does homework create conflict within the home:

YES NO

Has your child ever had a psychoeducational assessment:

YES NO

If yes, when was it completed:

Has your child been identified as having a Learning Disability:

YES NO

If yes, what is the identification:

Does your child have an Individualized Education Plan at school?

YES NO

GENERAL REVIEW:

What are your child's strengths:

What are your top three concerns about your child:

1)

2)

3)

When did you first notice your child having these problems:

Did your child ever have similar emotional or behavioural problems that concerned you when they were younger:

◯ YES ◯ NO

If yes, please describe these problems:

Has your child ever had direct contact with any social agency, psychologist, clinic or private agency:

◯ YES ◯ NO

If yes, please list:

Name of Professional Agency	Date of Service

Do you have extended health benefits that cover the cost of psychological services:

◯ YES ◯ NO

If yes, please give the details of the plan:

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