NANAIMO CHILD DEVELOPMENT CENTRE
Opening Doors®

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Vancouver Island Children's Assessment Network (VICAN) Intake

This information will be used and is critical to the clinical evaluation process.

CHILD'S INFORMATION

Child's Name: _____ Gender ❍ M ❍ F

Birth Date: _____ Age: _____

Name of Parents/Guardians: _____

Address: _____ Telephone (Home): _____

_____ (Work – Mom): _____

_____ (Work – Dad): _____

_____ (Cell): _____

Email: _____ Fax: _____

Family Doctor: _____ Paediatrician: _____

Language spoken at home: _____ Second language: _____

Does your family have any Aboriginal heritage? Yes ❍ No ❍

Please describe the questions you would like this assessment to help answer: _____

_____

_____

_____

_____

FAMILY HISTORY

Child is living with:

❍ Both parents ❍ Mother ❍ Father

❍ Mother and Stepfather ❍ Father and Stepmother ❍ Legal Guardian

❍ Other (please specify) _____

Is the child adopted? ❍ Yes ❍ No Child's age at adoption: _____

	Birth Mother	Birth Father
Current age:	_____	_____
Highest grade completed	_____	_____
Occupation:	_____	_____

Siblings	Age	Sex	In Home?	Developmental/Behavioural Learning/Health Problems?
_____				
_____				
_____				
_____				

BIOLOGICAL EXTENDED FAMILY

Do any extended family members (maternal/paternal grandparents, uncles, aunts, cousins) suffer from a problem with social difficulties, Autism, Asperger's, speech-language delays, epilepsy, seizures, migraines, alcoholism, substance abuse, psychological/emotional difficulties, personality difficulties, learning problems or other developmental disabilities; and/or a "nervous" or neurological" disorder; etc?

❍ Yes ❍ No

If yes, please list relationship to child, disorder, and any treatment received.

Maternal (mother's side)	**Paternal (father's side)**
_____	_____
_____	_____
_____	_____
_____	_____

Please provide any other information about the child's extended family that might help us understand the child's background and needs (developmental, psychological, medical, educational):

_____

_____

_____

BIRTH AND DEVELOPMENTAL HISTORY

Pregnancy

Mother's age at time of birth: _____ Length in months: _____

Any illnesses or complications while pregnant? ❍ Yes ❍ No

If yes, please explain: _____

Medications taken by the mother during pregnancy. Explain: _____

Substances used during pregnancy:

❍ Cigarettes How many? _____ Per ❍ day ❍ week

❍ Alcohol How many drinks? _____ Per ❍ day ❍ week ❍ Month

❍ Drugs

Please describe the type(s) of drug, frequency of use, and at what month of the pregnancy use was started/stopped (if applicable): _____

_____

Was the father taking any medication or drugs at the time of conception? If so, what?: ___

_____

How many pregnancies and/or miscarriages has the mother had? _____

Labour and Delivery

❍ Vaginal Delivery or ❍ Caesarean

❍ Did the baby have breathing problems? ❍ Cord around the neck? ❍ Poor colour?

Was the birth of the child 'normal'? ❍ Yes ❍ No If no, please explain: _____

_____

Perinatal History

Birth Weight: _____ Length: _____ APGAR Scores: _____

Did mother or baby require any special care? _____

Please list any birth defects: _____

Infancy and Early Childhood

Please rate the child on the following behaviours: Circle 1 if the behaviour on the lefts was present the majority of the time. Circle 5 if the behaviour on the right was present the majority of the time. Stages in between are represented by 2, 3, and 4. If there are two behaviours listed (e.g., tantrums and head banging), please check the one that is present.

Quiet and content	1	2	3	4	5	Colicky and irritable
Very easy to feed	1	2	3	4	5	Daily feeding problems
Slept well	1	2	3	4	5	Frequent sleeping problems
Usually relaxed	1	2	3	4	5	Often restless
Under active	1	2	3	4	5	Overactive
Cuddly, easy to hold	1	2	3	4	5	Did not enjoy cuddling
Easily calmed down	1	2	3	4	5	❍Tantrums ❍Head banging
Cautious and careful	1	2	3	4	5	❍Accident prone ❍Daredevil
Coordinated	1	2	3	4	5	Uncoordinated
Enjoyed eye contact	1	2	3	4	5	Avoided eye contact
Liked people	1	2	3	4	5	Disliked contact with people
Sociable	1	2	3	4	5	Unsociable or ignored others

Other problems or comments regarding infancy or early childhood development: _____

_____

_____

_____

Was your child separated from the primary caregiver during infancy for a period of time? If yes, please indicate for how long and for what reason: _____

_____

_____

_____

Developmental Milestones *(as best as you can remember)*

Gross Motor: Crawled _____ Walked alone _____ Ran well _____

Fine Motor: Fed self with spoon _____ Scribbled _____

Language: Used single words _____ Used sentences (2+ words) ____

No. of words in vocabulary (circle): 0 less than 10 10-20 20-50 50-100 100+

Speech or articulation problems: ❍ Yes ❍ No

Social/Adaptive: Toilet trained/day _____ Toiled trained/night _____

Rate of development overall: ❍ Slow ❍ Normal ❍ Fast

Handedness: ❍ Right ❍ Left ❍ Ambidextrous

MEDICAL HISTORY

Has the child had a head injury? ❍ Yes ❍ No

If yes, did he or she lose consciousness? ❍ Yes ❍ No For how long? _____

Was hospitalization required? ❍ Yes ❍ No For how long? _____

CT Scan? _____ MRI? _____ Seizures/convulsions/epilepsy? _____

Please provide additional information: _____

_____

_____

Has the child ever been diagnosed by a psychologist, physician or other professional as having Autism, Pervasive Developmental Disorder (PDD), or Asperger's disorder? ❍ Yes ❍ No

If no, do you feel that one of these diagnoses may be a possibility for your child? ❍ Yes ❍ No

If yes, when? _____

What treatment has the child received for Autism, PDD or Asperger's disorder? _____

_____

_____

Has the child been previously diagnosed with any other developmental, psychiatric or learning disorder? ❍ Yes ❍ No If yes, please explain: _____

_____

Medications (with dosage and times) **currently** being taken by the child, including non-prescription medications, herbal preparations, and vitamins. Please indicate what the medications are for: _____

_____

_____

Medications that have been taken by the child **in the past**, including non-prescription medications, herbal preparations, and vitamins. Please indicate what the medications were for: _____

_____

Has your child suffered frequent ear infections? ❍ Yes ❍ No If yes, at what age(s): _____

Did he/she require ventilation tubes in ears? ❍ Yes ❍ No If yes, at what age: _____

Date of last hearing test: _____ Were the results normal? ❍ Yes ❍ No

If no, please explain: _____

Date of last vision test: _____ Were the results normal? ❍ Yes ❍ No

If no, please explain: _____

Does the child wear: ❍ glasses? ❍ contact lenses?

The child's current health is: ❍ Poor ❍ Fair ❍ Good ❍ Excellent

BEHAVIOURAL AND MENTAL HEALTH HISTORY

Please describe any behaviours that are particularly concerning to you or others: _____

_____

_____

_____

_____

_____

Were there any unusual, traumatic or possibly stressful events in the child's life that you thing may have had an impact on his/her development and current functioning. Include incident, child's age at the time, and comments:

_____

_____

_____

_____

_____

_____

Has the child or family received any professional mental health treatment, such as individual or family counselling? ❍ Yes ❍ No

Please list any past and current treatments, including type of counselling, person counselled, name of counsellor, and length of treatment. _____

_____

_____

PRESENT PERSONALITY AND BEHAVIOUR (Please circle all traits that apply to the child ***now***.)

Sad	Happy	Talkative	Moody
Friendly	Quiet	Trouble sleeping	Independent
Sensitive	Affectionate	Prefers to be alone	Cooperative
Perfectionist	Sociable	Follower	Even tempered
Insistent on routine	Leader	Overactive	Responsible
Hard to discipline	Lethargic	Cautious	Dependent
Enjoys being around others	Fearful	Flexible	Tantrums
Poor judgement/sense of danger	Avoids or resistant to new things		

PEER RELATIONSHIPS (Please circle all traits that apply to the child.)

No friends	Few friends
Bossy/controlling	Mean/aggressive
Poor social judgement	Frequent social blunders
Naively trusting or vulnerable	Easily mis/lead by peers
Problems reading facial expressions	Loses friends
Unable to initiate play/games with peers	Often bullied
Difficulty verbally interacting with peers	Trouble making new friends
Difficulty discerning nonverbal clues	Uninterested in play/games with peers

Additional comments on peer relationships: _____

_____

_____

_____

PRESCHOOL/DAYCARE/SCHOOL INFORMATION

Is your child currently in preschool/daycare/school? ❍ Yes ❍ No

Current Facility: _____ Grade (if applicable): ____

Teacher: _____

What special services/designation (if any) does your child receive in preschool/daycare/school? __

_____

_____

_____

Signature of individual completing the form: _____

Date: _____