



1135 Nelson Street
Nanaimo BC V9S 2K4
Telephone: 250-753-0251
Fax: 250-753-5614
Email: info@nanaimocdc.com
www.nanaimocdc.com

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	<input type="radio"/> Tantrums <input type="radio"/> Head banging
Cautious and careful	1	2	3	4	5	<input type="radio"/> Accident prone <input type="radio"/> 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 think 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: _____

