STUDENT SERVICES
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PSYCHOLOGICAL SERVICES
BACKGROUND INFORMATION FORM

Please complete as much of this questionnaire as you can. It may help to understand and program for your child's difficulties, while discovering and utilizing strengths. Only persons directly involved in the assessment process will see the information that you include. Information that you do not want included in the psychological report can be marked in some way (e.g., crossed out, etc.). You may also decide to include information not requested on the form if you think it's important. This questionnaire comes with a large self-addressed envelope. After completing the form, please seal it in the envelope. Then, either mail it back, or return it to your child's learning support teacher, who will then forward it to the school psychologist.

A. IDENTIFYING INFORMATION:

Name of child: _____ Age _____ Sex _____

Date of birth: _____ Natural _____ Adopted _____ Foster _____

Address: _____

Home Phone: _____ Work Phone: _____

Names (s) of parents living at home: _____

_____

Names(s) & age(s) of child's siblings: _____

_____

_____

If foster, child's social worker: _____

Country of birth: _____ Date of arrival to Canada: _____

Countries in which you resided (dates): _____

Primary language(s) spoken at home: _____

LANGUAGE(S) SPOKEN AT HOME: check all that apply & indicate how much time for each:

Spoken by Parents			**Spoken by Children**		
Checkmark ✓	**Language**	**% of Time**	**Checkmark ✓**	**Language**	**% of Time**

*Other language spoken at home = _____

B. FAMILY HISTORY:

1. Have you or your spouse been previously married or lived common law?
   Yes ____ No ____ If yes, please specify: _____
   _____
2. Are you currently separated? Yes ___ No ___ or divorced? Yes ___ No ___ If so, when did this occur? (Specify): _____
3. Who has legal custody of the referred child?_____
4. If separated or divorced, describe the child visitation privileges: _____
   _____
5. If currently married, how long have you been together? _____
6. How many residential moves has your child experienced? _____
7. Have you or your spouse experienced any recent job loss? Yes ____ No ____. If yes, please specify: _____
8. Has anybody, to whom your child was close, died within the last year? Yes ___ No ___. If yes, please specify: _____
9. Has anybody in the child's family (immediate or extended) ever suffered from a mental disorder or serious illness? Yes ____ No ____. If yes, please specify:_____
   _____
   _____
10. Has anybody in the child's family (immediate or extended) ever had a learning disability in reading, writing, or math? Yes ____ No ____. If yes, please specify: _____
    _____
    _____
11. If currently married or living common law, estimate the average degree of adult partner conflict experienced by the referred child over the past month by selecting a rating anywhere from 1 (very low) to 10 (very high): _____
12. Has your child ever experienced any emotional trauma or abuse? Yes ____ No ____. If yes, please specify: _____
    _____
    _____
13. How well does your child get along with other family members? _____
    _____
    _____

14. List the types of chores for which your child is responsible at home: _____

_____

_____

15. How well does your carry out his/her chores at home? _____

_____

16. What behaviour problems does your child exhibit at home or in the community?

_____

_____

_____

_____

17. What types of disciplinary strategies do you use at home with your child to promote respectful and responsible behavior? _____

_____

_____

_____

18. How well do the disciplinary strategies work? _____

19. Please complete the educational data for each biological parent:

	Biological Father	**Biological Mother**
(A) Name	_____	_____
(B) Highest grade completed in school	_____	_____
(C) Post-secondary education	_____	_____
(D) Learning problems	_____	_____
(E) Occupation	_____	_____

20. Does your child have any difficulties completing homework? Yes ____ No ____. If yes, Please specify:

_____

_____

21. How much time does your child spend at home or doing homework or studying for tests? Please specify: _____

_____

22. Does anyone help your child with homework or studying? Yes ___ No ___. If yes, what assistance is provided? _____

_____

23. What type of reading supports are there at home (e.g., reading with your child, visiting local library, buying books, grandparent(s) or older siblings help, etc.)?

_____

_____

24. Does your child have access to a computer or tablet to access educational software or apps?

_____

25. Does your child get any private tutoring outside of school? Yes ___ No ___.

If yes, who provides the tutoring? _____

What subjects were academic skills are tutored? _____

How often does your child get tutored? _____

If tutored in the past, state who, when, and for what: _____

_____

C. DEVELOPMENTAL HISTORY:

1. Biological mother's age during pregnancy: _____ yrs.
2. Did the mother have a fever, infectious disease, or health problems during pregnancy? Yes ____ No ____ If yes, please specify _____

_____

3. Was any tobacco, alcohol, or other drugs used during the pregnancy? Yes ____ No ____ If yes, please specify substance & quantity:

_____

_____

4. Were there any complications during labour or delivery (e.g., breech birth, umbilical cord around neck, forceps delivery, cesarean section)? Yes ____ No ____ If yes, please specify: _____

_____

5. Was your child born (a) full term ____ (b) premature ____ (c) late ____? If (b) or (c) please specify by how much:_____
6. Child's birth weight: _____ Any severe jaundice? _____
7. Did your child have any colic? Yes ____ No ____. If yes, how long? _____

8. *Motor Development*: Please state age, if known, or whether development was slow, average, or early.
   (a) sitting up (usually by 6-9 mo.) _____ (b) crawling (usually by 9 mo.) _____
   (c) standing alone (usually by 12 mo.) _____ (d) walking alone (usually by 18 mo.) _____

9. *Speech Development*: Please state age, if known, or whether development was slow, average, or early.
   (a) Said 10-20 words (by ~ 1.5 yrs.) _____ (b) 2-3 word phrases (by ~ 2 yrs.) _____
   (c) 3-4 word sentences (by ~ 3 yrs.) _____

10. At what age was your child toilet trained? _____ yrs. Were there any difficulties (e.g., bed-wetting, daytime wetting, soiling, etc.?) If yes, specify: _____

    _____

    _____

    Does your child still have difficulties? Yes ___, No ___ If yes, how are you treating them? _____

    Do the difficulties (if any) affect your child at school? _____

11. Did the child, as a preschooler, repeatedly try to point out or share with his/her parent(s) newly discovered things, interests, and achievements? Yes ____ No ____. Does this occur now? Yes ___ No ____.

D. MEDICAL HISTORY:

1. Did your child have any severe illnesses, accidents, hospitalizations, or operations?
   Yes ____ No ____ If yes, please specify: _____

   _____

2. Did your child ever have high fevers, convulsions, seizures, or blank spells?
   Yes ____ No ____ If yes, please specify: _____

   _____

3. Did your child ever get knocked unconscious or have a concussion? Yes ___ No ___. If so, what caused it and how long did it last? _____

   _____

4. Did your child ever have a brain scan (e.g., CT, MRI, EEG)? If so, what were the results?

   _____

   _____

5. Did your child have ear infections or insertion of T-tubes?
   Yes ____ No ____ If yes, please specify: _____

6. Did your child have allergies or asthma? Yes ____ No ____ If yes, please specify:_____

7. Does your child have any difficulties sleeping (e.g., falling or staying asleep, waking early, snoring, sleep walking, getting up on time, etc.)?_____

8. Did your child ever ingest any poisons accidentally (e.g., lead, mercury, pesticides, etc.)?

9. Has your child received any medical diagnoses? Yes ____ No ____ If yes, please specify:

10. Has your child ever been prescribed any medication? If yes, please specify:_____

11. Please list the names of your child's medical doctor, any other specialists, and their phone numbers: _____

E. SPECIAL SUPPORT SERVICES:

1. Has your child had a thorough visual examination? Yes ____ No ____.
   If yes, where _____ When _____
   Results: _____
2. Has your child had a thorough hearing assessment? Yes ____ No ____.
   If yes, where _____ When _____
   Results: _____
3. Does your child have any physical handicaps? Yes ____ No ____.
   If yes, please specify: _____
4. Please note if your child has received services in the following areas:
   (a) Speech Therapy: Yes ____ No ____
   If yes, where _____ When _____
   (b) Reading Clinician: Yes ____ No ____ When _____
   (c) Psychological Assessment: Yes ____ No ____
   If yes, where _____ When _____
   (d) Social Work/Counselling: Yes ____ No ____
   If yes, where _____ When _____

(e) Occupational Therapy: Yes ____ No ____

If yes, where _____ When _____

(f) Physiotherapy: Yes ____ No ____

If yes, where _____ When _____

(g) Mental Health/Psychiatry: Yes ___ No ___

If yes, where _____ When _____

F. EDUCATIONAL HISTORY:

1. Please list your child's schools in order of attendance.

Name of School	Age	Grade	Special or Regular Class	Best Subjects	Worst Subjects

2. How would you describe your child's school attendance (e.g., regular, missed blocks of time, refusals, truant, etc.)? _____

_____

3. Has your child been misbehaving in school? Yes ____ No ____. If yes, please specify:

_____

_____

4. Have teachers used any special motivational or disciplinary strategies to try and change any of your child's behaviors? Yes ____ No ____. If yes, please specify: _____

_____

_____

5. Has your child received any resource help in school? Yes ____ No ____. If yes, please specify: _____

_____

6. Have your child's teachers tried any instructional adaptations or modifications to allow for a greater chance of academic success? Yes ____ No ____. If yes, please specify:

_____

_____

7. How much does your child like school on a scale from 1 (Low) to 10 (High)? _____
8. Does your child express any frustrations about school? _____

_____

G. CHILD'S PERSONALITY:

1. Please list the strengths, talents, and interests of your child: _____

_____

_____

_____

_____

_____

_____

2. Please put an "✓" over the point along each continuum below that best describes your child.

A.) ***Temperamental Traits*** **(starting from early on, when child was a toddler):**

Low Activity Level	____:____:____:____:____:____:____	High Activity Level
High Persistence	____:____:____:____:____:____:____	Low Persistence
Gentle	____:____:____:____:____:____:____	Forceful
Positive Moods	____:____:____:____:____:____:____	Negative Moods
Approaches Novelty	____:____:____:____:____:____:____	Avoids Novelty
Reflective (thinks first)	____:____:____:____:____:____:____	Impulsive (just acts)
Robust Senses	____:____:____:____:____:____:____	Irritable Senses*

NOTE: "*Irritable Senses*" – some children are sensitive or easily irritated by how things feel, smell, taste, sound, etc. They may communicate displeasure to caregivers, try to escape irritating situations, or avoid them. They may be exceptionally sensitive in some sensory systems (e.g., touch or hearing) but not as much in others (e.g., smell or taste). Other children with robust senses are not bothered much by how things feel, smell, taste, sound.

*If child has irritable senses, which systems are affected? Hearing___? Vision___? Touch ___?

Taste ___? Smell ___? What problems result from this? _____

_____

_____

H. EXTRA-CURRICULAR INVOLVEMENT:

1. Please list your child's hobbies: _____

_____

_____

_____

_____

2. Please list the types of sports with which your child is involved: _____

_____

3. Please list the organizations (e.g., clubs, teams) of which your child is a member:

_____

4. Please list the type of private lessons (e.g., piano, skating) your child is taking:

_____

5. How popular would you say your child is in school with other children on a scale from 1 (very unpopular) to 10 (very popular): _____
6. Does your child have any difficulty getting along with peers? _____

_____

7. About how many close friends does your child have? _____
8. How frequently does your child see his/her friends per week? _____
9. What does your child like to do with his/her friends? _____

_____

10. Has your child ever been bullied? _____

I. OTHER RELEVANT INFORMATION:

1. What concerns you most about your child's current functioning? _____

_____

_____

_____

_____

_____

_____

_____

2. When did the problem(s) about which you are concerned begin? How old was your child at the time? _____

_____

3. Please formulate your own ideas about the suspected cause of your child's problem(s):

_____

_____

_____

_____

_____

4. What are your hopes for your child as a result of this referral?

_____

_____

_____

_____

5. Please add any further information that may be relevant to this referral (e.g., What helps your child function better? What doesn't work?) _____

_____

_____

_____

_____

_____

FORM COMPLETED BY (NAME): _____

DATE: _____

THANK YOU FOR THIS INFORMATION

The personal information in this report is being collected under authority of Hanover School Division and will be used for educational purposes. It is protected by the privacy provisions of the Freedom of Information and Protection of Privacy Act (FIPPA) and the Personal Health Information Act (PHIA). This information may also be shared under the Provisions of the Protection of Children (information sharing) Act (PCISA). If you have any questions about the information collection, contact the Hanover Access And Privacy Coordinator at 326-9829.