

# 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:

	<b>Biological Father</b>	<b>Biological Mother</b>
(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: \_\_\_\_\_

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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):

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

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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?) \_\_\_\_\_

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**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.