CASA Centre
10645 63 Avenue
Edmonton, Alberta T6H 1P7
Phone: 780.400.2271
Intake Fax: 780.410.8499

Infant and Preschool Services Toddler/Preschool Intake Form

Age: 1 year to 4 years 9 Months

Collecting this information from parents/guardians before booking an appointment at CASA allows us to more accurately determine whether CASA Infant and Preschool Services are appropriate for this child, if the situation should be considered urgent or high priority, and also helps our assessment process work more efficiently. Providing this information is voluntary and it will be held in confidence, stored securely until the child is 18 years of age and accessed only by CASA staff and physicians.

The information collected on this intake form is used to access the services of Infant and Preschool Services, CASA Child, Adolescent and Family Mental Health and is collected pursuant to section 22 (2)(b) of the Health Information Act (HIA) in accordance with sections 20 (b) and 21 (1)(a) of the HIA. If you have any questions about the collection of this information, please contact the Human Resources and Health Records Officer at 780 400 4554. The Health Information Act and/or Freedom of Information Act protects the privacy of this information.

Child's Full Legal Name *(last name, first name, middle name)*			
Alberta Health Care Number (required)	Date of Birth (Day-Month-Year)	Age	Gender ☐ M ☐ F

Parent(s)/Guardian(s) Identification *[if the parent(s) is/are not the guardian, we require the guardian's information]

Parent/Guardian 1

Full Name _____

Please circle appropriate descriptors:

Biological Adoptive Step Foster Grandparent

Family Status: Married Common-law Divorced Separated

Address: 1._____

City 1._____

Postal Code: 1._____

Home Phone: 1._____

Alternate Phone: 1._____

Parent/Guardian 2

Full Name _____

Please circle appropriate descriptors:

Biological Adoptive Step Foster Grandparent

Family Status: Married Common-law Divorced Separated

Address: 2._____

City 2._____

Postal Code: 2._____

Home Phone: 2._____

Alternate Phone: 2._____

Are you or have you ever been involved with CASA? Please circle: Yes No

If yes, please specify: _____

Is your primary mode of transportation public transit? Please circle: Yes No

If parents are living apart, child mainly lives with: _____

Who has legal custody? (*please provide legal documentation if the family is no longer together*) _____

List everyone living in the home: _____

_____

_____

Does this child receive services from Child and Family Services? (please circle) Yes No

Services Received: _____

Case worker's name: _____ Phone Number: _____

Child's Guardianship Status (if applicable)

Permanent Guardianship Order: (PGO) _____

Temporary Guardianship Order: (TGO) _____ Expiry Date: _____ Interim Agreement:_____ Expiry Date: _____

Custody Agreement: _____ Expiry Date:_____

Please note that this child's guardian must sign this form before it can be accepted for review

Who referred this child to CASA Infant and Preschool Services? (Please Circle)

Parent *Physician* *Home Nutrition* *Glenrose* *Child and Family Services* *Headstart*

*Other:*_____

Name and phone number of referring party: _____

Name of current physician/pediatrician _____

Phone number of current physician/pediatrician _____

What concerns you about your child?

At home: _____

_____

At daycare/preschool: (if applicable) _____

_____

In the community: _____

_____

When was this problem first noticed? _____

_____

Has your child ever been a victim of abuse: (Please circle) *Yes* *No*

If 'yes' what was the nature of the abuse: (Please circle)

Physical abuse *Sexual abuse* *Emotional abuse* *Neglect*

Has your child ever experienced a traumatic event? (Please circle) *Yes* *No*

If 'yes' what was the nature of the event: (Please circle)

Witnessed violence *Disaster/Accident (fire, car accident etc.)* *Death of a close family member*

Other (please Specify): _____

___ _____

_____

_____

The following information will be helpful to our understanding of your child. Please place an 'x' or a '√' in the appropriate column as thoughtfully as possible. If you do not know an answer, indicate "don't know". Feel free to make additional comments in the space on the last page.

Have you noticed your child behaving in any of the following ways?	**Behaviour**		
	Current	**Experienced in the Past**	**Don't Know**
Fidgets with hands, feet or squirms in seat			
Acts like he / she is driven by a motor *(boundless energy)*			
Easily distracted			
Has problems following through with instructions *(usually not due to opposition or failure to understand)*			
Does unsafe activities like climbing on high objects and jumping off things			
Frustrates easily			
History of temper tantrums			
Outbursts of physical aggression towards others			
Mood is often up and down			
Appears sad much of the time			
Cannot be consoled by caregiver			
Cries excessively			
Has many fears *(e.g. bugs, the dark)*			
Worries excessively			
Obsesses over things			
Does things over and over *(i.e. hand washing, lining up toys)*			
Needs things done in a certain way			
Collects things			
Often complains of headaches/stomach aches			
Restless sleeper (*kicks legs, moves around*)			
Frequent nightmares/night terrors (*wakes up crying/screaming*)			
Has difficulty falling asleep (*greater than 20 minutes*)			
Wakes often			
Will often simply refuse to eat			
Extreme pickiness with eating			
Eats large amounts (*doesn't ever seem to be full*)			
Reacts strongly to loud noises or certain tastes			
Is very particular with the ways things feel *(clothing etc.)*			
Holds his/her bowel movements			
Has trouble with toilet training			
Has problems with constipation			
Excessive self injurious behaviours *(bangs head, hits self, bites etc.)*			

Delivery / Birth History

Before Delivery:

Was the biological mother healthy during the pregnancy? (please circle) Yes No

If 'no', please explain. Were there any complications such as depression, anxiety, diabetes, German measles (*rubella*), high blood pressure, medications?

_____

_____

_____

_____

At what month of gestation was the pregnancy confirmed? _____

What was the duration of the pregnancy? _____

Delivery:

Please circle one: *Full term* *Premature* *Overdue* Birth Weight: _____

C-Section: Yes No Duration of labor: _____

Following birth did the infant have trouble starting to breathe? *(Please circle)* Yes No

Describe any difficulties with the delivery:_____

_____

_____

Was there post partum depression?_____

After Delivery:

Did the child, as an infant, experience any of the following: (please check any that apply)

☐ breathing problems

☐ colic

☐ jaundice

☐ neonatal care

☐ difficulty sucking

Was your child (please circle one) *breast fed* *bottle fed*

Does your child have a congenital condition or developmental difficulties? (please circle) Yes No

*(If yes, please describe)*_____

_____

_____

Child's Medical History

What is the current height and weight of your child? Height: _____ Weight:_____

Has your child ever seen a professional for any of the following?

- ☐ Ear infections
- ☐ Weight Problem
- ☐ Broken bones
- ☐ Constipation
- ☐ Hearing problems
- ☐ Feeding Problems
- ☐ Head injury
- ☐ Allergies
- ☐ Vision problems
- ☐ Sleep problems
- ☐ Breathing problems
- ☐ Seizures
- ☐ Experienced trauma
- ☐ Dental problems
- ☐ Other:(please describe) _____

Has your child ever been hospitalized for illness, surgery, or injury? If so, please explain why and when:

_____

_____

_____

_____

Is your child on any medication? (please circle) Yes No *(If yes, please specify)*

_____

_____

Developmental History

Please indicate if you had or currently have concerns with your child's development *(eg. Walking, talking, toilet training)*

_____

_____

_____

Please indicate if you had or currently have concerns with the bonding/relationship with your child:

_____

_____

_____

Has your child had any of the following assessments or interventions? If so, please mark the appropriate categories and include copies of the reports.

- ☐ Speech/language
- ☐ Occupational therapy
- ☐ Education
- ☐ Psychiatry/mental health
- ☐ Hearing/audiology
- ☐ Psychology/counselling
- ☐ Physical therapy
- ☐ Other *(please specify)***:**

Is there any biological family history of the following?

	Yes	No	Relationship to child		Yes	No	Relationship to child
Learning difficulties				Family violence			
Depression				Hyperactivity/ADHD			
Addictions				Sexual abuse			
Suicide				Seen a psychiatrist or counsellor			

Do you use any of the following parenting/discipline techniques with your child?

☐ Time outs ☐ Choices ☐ Natural consequences

☐ Reward or sticker charts ☐ Redirection ☐ Verbal limits ☐ Physical limits(spanking etc.)

Daycare/Preschool/School Information

Name of present preschool, daycare or day home	Age Started	Length of Time Attended
Name of previous preschool, daycare or day home?	Dates Attended	Length of Time Attended

Has your child been asked to leave a daycare /day home/ preschool due to his/her behaviours? If yes, how many?

_____

_____

_____

What is your child's favorite thing to do?_____

_____

_____

What do you like about your child?_____

_____

_____

_____

_____

_____

Please add any other information regarding your child's behavior that you feel would be important for us to know.

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of the person completing this form Date

_____

Relationship to this child

Guardians are required to sign this form to ensure they are aware of this request for services from CASA Child, Adolescent and Family Mental Health.

- **If both biological parents live together, only one parent is required to sign this form.**
- **In the case where the child's biological parents' are not living together, we require signatures from both parents unless sole custody has been defined and the legal documentation confirming sole custody is provided with this form.**
- **If guardianship involves Children's Services, the child's Children's Services Worker is required to sign this form and <u>must</u> be present for the initial assessment at CASA.**

_____ _____ _____

Signature of legal guardian *Relationship* *Date*

_____ _____ _____

Signature of legal guardian *Relationship* *Date*

If you have any concerns or questions please contact CASA at (780) 400-2271.

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