



CLIENT AND FAMILY INFORMATION FORM: PRESCHOOL AGE (0-4 YEARS)

Please complete all sections of this form to ensure prompt processing.

* Denotes a required field

NOTE: This information will be shared with ISAND staff as required

Please email, mail, fax or return this form in person:

Integrated Services for Autism and Neurodevelopmental Disorders
5734 Yonge Street, Suite 500 Toronto, ON Canada M2M 4E7

Telephone: 416.224.5959 Facsimile: 416.224.2772 Email: info@isand.ca

Charitable Registration No: 84141 7538 RR0001

Upon completion of this form:

Save the file by going to "file" then "save." Save it to your computer and then attach it into an email and send to info@isand.ca

COMPLETED BY:

TODAY'S DATE:

CLIENT INFORMATION*

Last name: First name: Goes by:
Date of birth: Gender:
Home address:
City: Province: Postal code:
Health card number: Version code: Expiry:
Language(s) spoken at home:
Any brothers/sisters? Yes No List by name (age):

PARENT/GUARDIAN INFORMATION*

PARENT/GUARDIAN 1 (PRIMARY CONTACT FOR APPOINTMENTS)

Mr. Mrs. Ms. Dr. Last Name: First Name:
Occupation:
Address (if different from child's):
Primary telephone No.: Home Cell Work
Other telephone No.: Home Cell Work
Email address:
I prefer to be contacted by: Email Phone

PARENT/GUARDIAN INFORMATION (cont'd)

PARENT/GUARDIAN 2

Mr. Mrs. Ms. Dr. Last Name:

First Name:

Occupation:

Address (if different from child's):

Primary telephone No.:

Home Cell Work

Other telephone No.:

Home Cell Work

Email address:

I prefer to be contacted by: Email Phone

Emergency contact name*:

Phone*:

RELATIONSHIP STATUS

Married/Common-Law Separated Divorced Single Widow/Widower

The child currently lives with:

Both parents Mother Father Grandparent(s) Foster Family Other

Who has legal custody of your son/daughter?

Both parents Mother Father Grandparent(s) Foster Family Children's Aid Society

Other

EXTENDED HEALTH CARE COVERAGE AND FINANCIAL ASSISTANCE

Do you have any extended health care coverage through private and/or group insurance?

Parent/Guardian 1: Yes No Not sure

Parent/Guardian 2: Yes No Not sure

Do you receive any financial assistance? Yes (check all that apply) No

Special Services at Home (SSAH)

Assistance for Children with Severe Disabilities (ACSD)

Assistive Devices Program (ADP)

Incontinence Supplies Grant Program (Easter Seals)

Disability Tax Credit

Trillium Drug Program

Ontario Disability Support Program (ODSP)

Other:

Funding via "Jordan's Principle" serving First Nations/Metis/Inuit

WHAT BRINGS YOU TO ISAND?*

How did you hear about ISAND?

Doctor Friend Website Social Media Other:

What are some of your child's strengths and interests?

What are your main reasons for contacting ISAND? Please rank your top 3 in order of concern

1)

2)

3)

Is there a specific program or service you are interested in?

Augmentative Communication (using pictures / tablet to talk) Behavioural Therapy

Counseling – Individual and Family

Developmental Medical Care

Educational Consultation

Occupational Therapy (sensory / motor needs / daily activities / leisure)

Psychology Services – Developmental or Psycho-educational Assessment

Psychology Services – Parent Consultation

Social Peers Program (2 yrs - adolescent)

Social Thinking Groups (10+ yrs)

Feeling Social Group (10+ yrs)

Speech and Language Therapy – Assessment

Speech and Language Therapy – Intervention

Yoga

Does your son/daughter have any allergies? Yes (please list below) No

HEALTH AND DEVELOPMENTAL INFORMATION*

PRENATAL HISTORY

Were there any worries about the pregnancy and possible effects on your child's development?

Yes (please specify) No

Was pregnancy a stressful time? Yes (please specify) No

Were there any thyroid problems during pregnancy? Yes (please specify) No

Were there any fevers during pregnancy? Yes (please specify) No

Were any medications taken during the pregnancy (please specify)?

BIRTH HISTORY

Pre-term (weeks):

Full term (38 weeks+):

Birth weight:

Any concerns during delivery (please specify: vaginal delivery or c-section)?

Any interventions required (please specify)?

NEONATAL PERIOD

Any admission to special care baby unit? Yes (please specify) No

Severe jaundice requiring treatment? Yes (please specify) No

Early feeding: breast fed bottle fed both

HEALTH AND DEVELOPMENTAL INFORMATION* (cont'd)

CHILD DEVELOPMENT

When did your son/daughter achieve key milestones:

smiling	rolling over	sitting unaided	standing
babbling	speaking	toileting skills	

Normal growth – Is the child following weight and height percentiles? Yes No

Please specify

Gastrointestinal Issues (select all that apply, if selected, please specify)

colic	reflux
constipation	diarrhea
other:	

Has your child ever been diagnosed with any of the following? (please check all that apply, add date of diagnosis)

Autism Spectrum Disorder	Asperger Syndrome	PDD-NOS
Rett Syndrome	Fragile X Syndrome	Down Syndrome
Tourette Syndrome	Global Developmental Delay	Cognitive Delay
ADD/ADHD	Anxiety or Mood Disorder	Epilepsy or seizure disorder

Other medical or genetic conditions (please specify):

HEALTH AND DEVELOPMENTAL INFORMATION* (cont'd)

Does your son/daughter have or experience any of the following? (select all that apply, if selected, please specify)

SELF-CARE / FINE & GROSS MOTOR / SENSORY

Difficulty with toileting

Wears Diapers

Difficulty using utensils to eat and/or holding a marker for drawing / writing

Picky eating or limited diet

Bothered by sensations: loud noise, bright light, certain textures, clothing

Engaging in unusual movements or mannerisms (hand flapping, head banging, spinning)

Gets upset when getting: dressed teeth brushed hair washed or brushed nails cut

Plays with toys or other things in unusual ways

For office use:

HEALTH AND DEVELOPMENTAL INFORMATION* (cont'd)

Does your son/daughter have or experience any of the following? (select all that apply, if selected, please specify)

EMOTIONAL REGULATION / BEHAVIOURAL CONCERNS

Difficulty falling asleep or sleeping through the night

Difficulty regulating his/her mood (worries, tantrums, withdraws, cries for no reason)

Difficulty going from one activity to another / gets upset by changes in plans/routines

Difficulty separating from parents

Hurts self or others

Difficulty participating in community outings (e.g., shopping, appointments, parties)

Safety risk (runs away, approaches strangers, destroys items)

For office use:

HEALTH AND DEVELOPMENTAL INFORMATION* (cont'd)

RECEPTIVE LANGUAGE (COMPREHENSION) SKILLS

Are his/her language understanding skills similar to peers:	yes	no / delayed	advanced
If No:			
Does he/she respond when their name is called?	yes	no	emerging
Can he/she follow 1 step commands in daily routines?	yes	no	emerging
Can he/she follow two step commands?	yes	no	emerging
Can he/she understand yes/no questions?	yes	no	emerging
Can he/she understand who/what/where questions?	yes	no	emerging
Can he/she understand when/why/how questions?	yes	no	emerging

EXPRESSIVE LANGUAGE SKILLS (SPONTANEOUS)

Speech Level:	sounds or words	2 word phrases	3+ word phrases	conversation
Intelligibility: How much of their natural speech can you understand?	25%	50%	75%	100%
How much can unfamiliar partners understand?	25%	50%	75%	100%
Other: Voice output device:	Picture exchange system:	photos?	symbols?	text?

Sign Language:

Gestures:	waves hi/bye	'high 5'	points	leads by hand	approaches people/items	
Functions:	greet	request	protest	inform	question	socialize

SOCIAL COMMUNICATION

Poor eye contact	Prefers to be alone
Seems interested in watching other children	Difficulty playing with others
Tends to dominate interactions when playing	Difficulty taking turns with adults
Difficulty taking turns with siblings/peers	Rarely responds to other children
Seems to obsess with objects	Seems to obsess with topics or themes
Talks too much	Talks too little

Comments:

MEDICATIONS OR SUPPLEMENTS*

Is your child currently taking any medication(s) or supplement(s)? Yes (please list below) No

Medication name	Dosage	Frequency	Date started	Effective(Y/N)?
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Previous medications trialed:	Outcome:	Comments:
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HEALTH CARE PROFESSIONALS*

Family Doctor Name: Phone #:

Paediatrician Name: Phone #:

Is this a developmental paediatrician? Yes No

ADDITIONAL SERVICES:

Social Worker / Psychologist Name: Phone #: Current Past

Speech-Language Pathologist Name: Phone #: Current Past

Occupational Therapist Name: Phone #: Current Past

Behavioural Therapist Name: Phone #: Current Past

Other service Name: Phone #: Current Past

Has your child had any of the following:

Vision screening Hearing screening Genetic testing (findings)

Neurologic tests (e.g., MRI, EEG; if selected please give result details)

Has your child had any overnight stays in hospital? Yes (please give details) No

EDUCATION*

Is your child enrolled in school, preschool or day care? Yes (please complete below) No

Name of preschool / daycare:

Grade:

Phone #:

School board:

OR Private school

What type of classroom is your child in?

Fully integrated (Regular) Partially integrated Specialized

If Specialized specify: ASD class DD or Mild Intellectual Disability Gifted Immersion

Has your child's teacher expressed any concerns about your child's learning, development, or behaviour?

Yes (please describe below) No

Has there been an IPRC (Identification, Placement, Review Committee) meeting? Yes No Not sure

Does your child have an Individualized Education Plan (IEP)? Yes No Not sure

Is your child on a modified or accommodated curriculum? Yes No Not sure

Does your child receive extra assistance at school?

Yes (please describe below) No

Educational assistant (if selected, please specify)

Class withdrawal with Special Education Resource Teacher (if selected, please specify)

How many hours of the day?

Has your child participated in any clubs, teams or activity groups?

Yes (please describe below) No

What are your child's interests, hobbies, and preferred activities?

ADDITIONAL INFORMATION

Is there any other information you would like to share with us that would help us to understand your child or your family's current situation?

I certify that all of the above information is true and accurate to the best of my knowledge and understanding.

SIGNATURE: