ISAND | INTEGRATED SERVICES FOR AUTISM AND NEURODEVELOPMENTAL DISORDERS

CLIENT AND FAMILY INFORMATION FORM: SCHOOL AGE (5-14 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: Male Preferred Pronouns: he/him

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)

☐ Assistive Devices Program (ADP)

☐ Disability Tax Credit

☐ Ontario Disability Support Program (ODSP)

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

☐ Assistance for Children with Severe Disabilities (ACSD)

☐ Incontinence Supplies Grant Program (Easter Seals)

☐ Trillium Drug Program

☐ Other:

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 ◯ 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

HEALTH AND DEVELOPMENTAL INFORMATION* (cont'd)

SOCIAL COMMUNICATION

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

Previous medications trialed: Outcome: Comments:

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? ◯ Yes (please complete below) ◯ No

Name of school: 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?

What is your child's reading level? Reading comprehension level?

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:

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