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Child and Family Profile

Children's Developmental Services

Child's Name:	Date of Birth:	Expected Date of Birth:
Assessment Date: Location:		Chronological Age: Corrected Age:
Staff Name:		DC OT RC
Caregivers:	Custody (please bold): Joint Sole Foster Other: explain Are you the biological parent(s)? YES NO Are you the legal guardian? YES NO	
Our family includes: (others living in the house)	Primary language(s) spoken in the home:	

TELL ME ABOUT YOUR CHILD (F-words*)
How are they involved in FAMILY* life? (Talk about the types of activities you do together.)
What does your child like to do for FUN*? (Talk about the activities your child enjoys most.)
Tell me about your child's FRIENDS*? (Talk about the social connections in your child's life.)
Tell me about how your child FUNCTIONS*? (Talk about how your child plays and functions in their daily life.)
How does your child participate in FITNESS*? (Talk about how your child is active and healthy.)
What do you see in your child's FUTURE*? (Talk about your family and child's dreams and expectations about the future.)

CURRENT CHILDCARE/PLANS FOR CHILDCARE:
Name of centre, location/site: We plan to attend childcare: Yes No Undecided at this time our plan is: Start date: How many days/week: ½ day-am ½ day-pm full-day M T W Th F M-F
PRENATAL HISTORY

Rosenbaum, P., & Gorter, J.W. (2012). The 'F-words' in childhood disability: I swear this is how we should think! Child: Care, Health and Development, 38(4), 457 – 463. DOI: 10.1111/j.1365-2214.2011.01338.x; CanChild's F-words Knowledge Hub: www.canchild.ca/f-words

Prenatal Information: (complications, high-risk pregnancy, IVF, mother's experience, mother's health, stressors, etc.)

Alcohol consumed during pregnancy Amount:

Recreational drugs used during pregnancy Type/Amount:

Prescription drugs taken during pregnancy Type/Amount:
Reason for medication (Are you aware of any risks to baby as a result of the medication):

BIRTH HISTORY: CHILD'S BIRTH INFORMATION

Hospital(s):	Gestational age at birth:___________ (weeks) Birth weight:
Length of Child's stay in hospital:	Was your child transferred to the Neonatal Intensive Care Unit (NICU)? YES NO
Length of Mother's stay in hospital:	Involved with NNFU Program? YES NO Name of program:

Consent for discharge summary: YES NO

Additional Birth Information: (Breathing difficulties, oxygen, intubation, CPAP, jaundice, feeding difficulties, medical information)

Adjustment to Caregiving: (Any concerns about Perinatal mental health-mental health after birth such as post-partum depression? Do you or your family have or need support?)

How are you as a caregiver coping with your current situation?

CHILD'S HEALTH

How has your child's health been since their birth? (medical interventions, illnesses, hospital stays?)

Special Tests (i.e. vision, hearing, MRI, head ultrasound, EEG, genetic testing, swallow study)

Test	**Date (or age) when completed**	**Results**
Hearing YES NO		
Vision YES NO		

Is your child on any medication YES NO

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Name of Medication	Reason for Medication (e.g. reflux, seizure medication, stimulants, anti-anxiety, asthma)	Known side effects of meds?	Date started	Date ended

FAMILY AND BIOLOGICAL HISTORY

Has anyone in your family experienced delays in their development or received a formal diagnosis?

YES NO …Please explain and relationship to your child:

Do any of your child's primary caregivers have a history of a mental health concerns? (Primary Caregiver may wish to discuss with other caregivers prior to sharing with CDS)

YES NO …Please explain and relationship to your child:

OTHER SUPPORTS/PROFESSIONALS (paediatrician, family doctor, specialists, neonatal follow-up program, financial assistance, OT, PT, SLP, private services)

		initiated	ended
Name: Specialty:	Contact Info: Next appointment:		
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Additional Information: any other important information shared by caregivers

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