Lakeland Centre for FASD
P.O. Box 479
4823 50th Street
Cold Lake, AB

New Client Information Form - Children and Youth

Date:

Child/Youth's Legal Name: _____

Date of Birth: _____ Health care #: _____

Gender: _____ Ethnicity: _____ Treaty #: _____

Legal Guardian(s): _____

Relationship to child/youth: _____

Mailing Address: _____

Phone #: _____ Cell #: _____ Email: _____

Caregiver(s) Name *If different*: _____

Home Address: _____

Mailing Address: _____

Phone #: _____ Cell #: _____ Email: _____

Who is requesting this assessment? _____

Birth Parents Information:

Birth Mother: _____

Date of Birth: _____

Birth Father: _____

Date of Birth: _____

Child Welfare Agency Information: *(if applicable)*

Caseworker: _____

Agency: _____

Phone #: _____ Fax#: _____ Email: _____

Legal status of child/youth: PGO ☐ TGO ☐ Voluntary placement agreement ☐ Kinship ☐ Other _____

Please attach a copy of appropriate order.

Education:

Is the child attending day care or school: Yes ☐ No ☐
Current school:
Grade:
Location:
Name of Primary Contact:
Phone #:

Previous Schools *(if applicable)*:

Name of School	Grades attended	Location

Assessments: Has the individual been assessed by:

	Location(s) and/or name of clinician(s)	Date(s) of assessment(s)	Report(s) attached	Currently involved
FASD Clinic				
Speech & Language Pathology				
Occupational Therapist				
Pediatrician				
Psychology				
Psychiatry/Mental Health				
Other				

Developmental and/or Behavioral Concerns:

Please describe current or past developmental or behavioral concerns:

Has the child/youth had difficulty with any of the following?

- ☐ Gross motor skills (use of large muscles like running, walking, climbing) _____
- ☐ Fine motor skills (use of hands and feet) _____
- ☐ Language skills _____
- ☐ Self control skills (impulse control, hyperactivity, attention span) _____
- ☐ Self concept (child's opinion about their appearance or abilities) _____
- ☐ Bed wetting or soiling _____
- ☐ Social skills (How your child gets along with other children) _____
- ☐ Growth _____
- ☐ Feeding (drinking, chewing or swallowing food) _____
- ☐ Reactions to noise, lights, touch, or movement _____
- ☐ Sleeping (Settling for sleep or sleeping through the night) _____
- ☐ Alcohol and drug use _____
- ☐ Running away_____
- ☐ Self harm _____
- ☐ Breaking the law _____

Describe the child/youth's current strengths and interests:

Medical History:

Hospital born at: _____

Location: _____

Hospital(s) treated at:	Location(s)

Does the child/youth have any history of the following? If so, please specify.

☐ Chronic illness	Explain:
☐ Hearing concerns	Explain:
☐ Vision concerns	Explain:
☐ History of seizures	Explain:
___ Any other medical conditions or diagnosis? Please list and explain:	
Is the child/youth currently being followed/treated for the above conditions? Yes ☐ No ☐	

Please list any medications the child/youth is currently taking:

Has anyone in the child/youth's family ever had any of the following?

☐ Autism ☐ Cerebral Palsy ☐ FASD ☐ Learning disability ☐ Developmental delay

☐ ADHD ☐ Speech & language delays ☐ Birth defects

☐ Specific genetic syndrome *(Down syndrome, dwarfism, cystic fibrosis, sickle cell disease, hemophilia, etc.)*

Additional information (optional):

Prenatal History:

Was alcohol used in the pregnancy? _____ Type(s) of alcohol: _____

First Trimester (1 to 3 months) ☐ Yes ☐ No ☐ Suspected ☐ Unknown ☐

Second Trimester (4 to 6 months) ☐ Yes ☐ No ☐ Suspected ☐ Unknown ☐

Third Trimester (7 to 9 months) ☐ Yes ☐ No ☐ Suspected ☐ Unknown ☐

Average # of drinks per occasion: _____ Maximum # of drinks per occasion: _____

# of drinking occasions per week: _____ Source of confirmation: _____

Other exposures during this pregnancy:

☐ Marijuana ☐ Cocaine ☐ Solvents ☐ Prescription drugs ☐ Other, *specify*_____

Comments:

Birth Mothers Pregnancies: *Please include miscarriages and still born births.*

Year	Length of pregnancy	Born live?	First name	Normally Developed?	Not Normally Developed? Explain.

Social History: *if applicable*

Date of child/youth's admission to agency care: _____

Reasons for coming into care:

Please list placements from birth:

Type of placement *(Foster, adoptive, group home, etc.)*	Length of placement	Age when placement started

Current placement:

Total number of adults currently residing in home: _____

Total number of children currently residing in home: _____

Number of biological siblings currently residing in home: _____

Family visits: *please describe the frequency and with whom the child/youth visits.*

Has the child/youth experienced or witnessed any of the following:

☐ Physical abuse	☐ Sexual Abuse	☐ Emotional abuse
☐ Emotional neglect	☐ Abandonment	☐ Family violence
☐ Multiple caregivers	☐ Sexualized behaviors	☐ Physical neglect
☐ High conflict custody situation	☐ Significant losses	☐ Other potentially traumatic events

Please provide details of any of the above concerns: