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Developmental Paediatrics
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Fax: 1-866-846-6939

Date 2025 -- --

Student Name:

Birth date: -- -- --

Grade level or placement:

Gender:

Health Insurance Number (OHIP): Version Code

Form completed by:

Relationship to subject:

	Mother	Father
Relationship to child		
Address		
Email		
Home Phone		
Business Phone		
Occupation		

Who initiated this referral?

Please list your main concerns:

Are there any specific questions you would like answered?

School your child is currently attending	
Name	
Teacher name(s)	
Teacher email(s)	
Grade	

School(s) that your child has attended			
Name	Year	Grade	Concerns

Physicians & Psychologists involved in the last 5 years	
Name	Regarding

Consultations				
Type		Year	Location	Currently Involved
Psychological Assessment	☐			☐
Speech & Language Assessment	☐			☐
Occupational / Physiotherapist	☐			☐
Audiology / Hearing	☐			☐
Vision	☐			☐

Are there any consultations planned in the next 6-12 months? ☐

Has your child taken over the counter products or prescribed medications for this before? ☐

If yes, please specify:

Pregnancy history:

Any medical problems or concerns you may have had?

Birth history:

Any medical problems or concerns you may have had?

Child's early development and medical history:

Any medical problems or concerns you may have had?

Do you believe any of the following milestones were reached late? If so, at what age?

	Delayed?	Age
Sat up without help	☐	
Walked alone 10-15 steps	☐	
Walked upstairs	☐	
Used fingers to feed	☐	
Used a spoon	☐	
Toilet trained (day)	☐	
Toilet trained (night)	☐	
Spoke first words	☐	
Put 2-3 words together	☐	
Crawled	☐	
Rode tricycle	☐	
Used sentences	☐	

Any of the following problems?

		Specify
Feeding difficulties	☐	
Poor appetite	☐	
Constipation	☐	
Recurrent stomach-aches	☐	
Sleep problems	☐	
Poor eating habits	☐	
Wetting the bed	☐	
Irritability, crying oft en	☐	
Short attention span	☐	
Destructive	☐	
Defiant, negativistic	☐	
Shy with strangers	☐	
Solitary play	☐	
Avoids eye contact	☐	
Unusual/odd mannerisms	☐	
Rocking/head banging	☐	
Usual fears	☐	
Resistant to change of routine	☐	

Any of the following problems?

Overactive	☐	
Under-active	☐	
Soiling pants	☐	
Aggressive	☐	
Frequent temper tantrums	☐	
Breath holding spells	☐	
Dependent	☐	
Hurting self (biting, hitting)	☐	

Any of the following medical problems?

		Age	Details
Ear infections	☐		
Rash/skin problems	☐		
Seizures	☐		
Recurrent infections	☐		
Allergies	☐		
Head injury	☐		
Meningitis	☐		
Operations	☐		
Eye problem	☐		
Casts/braces	☐		
Hospitalization	☐		
Other serious illness	☐		

Family History

	Biological Mother	Biological Father
Age		
Marital Status		
Cultural Heritage		
EDUCATION		
Years of post-secondary education		
Highest grade completed		
Learning problems (please specify)		
Focusing problems (please specify)		
Conduct issues (please specify)		
Attended special class		
Health problems		
Emotional or psychiatric disorders (please specify)		

Siblings

Name	Age	Sex	Grade	Relationships (full / half / step)

Do any family members have the following?

		Please specify
Focus problem / ADHD	☐	
Genetic disorder	☐	
Learning, reading problem	☐	
Mental retardation	☐	
Speech problem	☐	
Developmental delay	☐	
Bedwetting	☐	
Hearing difficulties	☐	
Visual problem	☐	
Difficult behaviour	☐	
Emotional / Psychiatric problem	☐	
Depression	☐	
Cerebral palsy	☐	
Thyroid problem	☐	
Birth defect	☐	
Other	☐	

OBSERVATION	Not at all	Just a little	Pretty much	Very much
INATTENTION				
Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities	○	○	○	○
Often has difficulty sustaining attention in tasksor play activities	○	○	○	○
Often does not seem to listen when spoken to directly	○	○	○	○
Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)	○	○	○	○
Often has difficulty organizing tasks and activities	○	○	○	○
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mentaleffort (such as schoolwork or homework)	○	○	○	○
Often loses things necessaryfor tasks or activities (e.g., toys, school assignments, pencils, books, or tools)	○	○	○	○
Is often easily distracted by extraneous stimuli	○	○	○	○
Is often forgetful in daily activities	○	○	○	○

HYPERACTIVITY				
Often fidgets with hands or feet or squirms in seat	○	○	○	○
Often leaves seat in classroom or in other situations in which remaining seated is expected	○	○	○	○
Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, maybe limited to subjective feelings of restlessness)	○	○	○	○
Often has difficulty playing or engaging in leisure activities quietly	○	○	○	○
Is often "on the go" or often acts as if "driven by amotor"	○	○	○	○
Often talks excessively	○	○	○	○
IMPULSIVITY				
Often blurts out answers before questions have been completed	○	○	○	○
Often has difficulty awaiting turn	○	○	○	○
Often interrupts or intrudes on others (e.g., butts into conversations or games)	○	○	○	○

Have there been any unusual stresses on child and/or family?

Is there any additional information that would help the doctor understand the child/family and the specific concerns that you have?

Please attach copies of the child's latest assessment or progress reports and include any other information that may be helpful

Thank you!
Please fax completed questionnaire to 1-866-846-6939 or scan and email to drcjspaeds@icloud.com