CASA Centre
10645 – 63 Avenue
Edmonton, Alberta T6H 1P7
Phone: 780-438-0011
Fax: 780 437-6133

Infant and Preschool Services Intake Form (Age: Birth to 4.5 years)

Collecting this information from parents/guardians before booking an appointment at CASA allows us to more accurately determine whether CASA Infant and Preschool Services are appropriate for this child, if the situation should be considered urgent or high priority, and also helps our assessment process work more efficiently. Providing this information is voluntary and it will be held in confidence, stored securely until the child is 18 years of age and accessed only by CASA staff and physicians.

The information collected on this intake form is used to access the services of Infant and Preschool Services, CASA Child, Adolescent and Family Mental Health and is collected pursuant to section 22 (2)(b) of the Health Information Act (HIA) in accordance with sections 20 (b) and 21 (1)(a) of the HIA. If you have any questions about the collection of this information, please contact the Director, Human Resources and Administrative Services at 780 415 6691. The Health Information Act and/or Freedom of Information Act protects the privacy of this information.

Child's Full Legal Name *(last name, first name, middle name)*			
Alberta Health Care Number *(required)*	Date of Birth *(Day-Month-Year)*	Age	Gender ☐ M ☐ F
Street and Mailing Addresse(es)			
City / Town	Province	Postal Code	
Parents Living with the Child			
Mother's Full Name	☐ Biological ☐ Step ☐ Foster	Age	
Home Phone Number:	Work Phone Number:	Cell Phone Number:	I am available for an appointment on short notice, please contact me. ☐
Father's Full Name	☐ Biological ☐ Step ☐ Foster	Age	
Home Phone Number:	Work Phone Number:	Cell Phone Number:	I am available for an appointment on short notice, please contact me. ☐
Other Agencies/Services Currently Involved:			
Custody Status	**Guardianship**		
Please provide a copy of the custody agreement.	Documents provided? **No** **Yes**		
What are the concerns about this child? For how long?			

Name

Infant and Preschool Intake Form

The following information will be helpful to our understanding of this child. Please fill in the blanks as thoughtfully as possible. If you do not know an answer, write "don't know". Feel free to make additional comments in the space on the last page.

Have you noticed this child behaving in any of the following ways?	**Current Behaviour**	**Behaviour experienced in the past**
Fidgets with hands, feet or squirms in seat	☐	☐
Appears sad	☐	☐
Easily distracted	☐	☐
Has difficulty awaiting his/her turn in games or group situations	☐	☐
Worries excessively	☐	☐
Has problems following through with instructions *(usually not due to opposition or failure to understand)*	☐	☐
Has difficulty paying attention during tasks or play activities	☐	☐
Shifts from one incomplete activity to another	☐	☐
Has difficulty playing quietly	☐	☐
Often talks excessively	☐	☐
Interrupts or intrudes on others *(often not purposeful or planned but impulsive)*	☐	☐
Does not appear to listen to what is being said	☐	☐
Can't sit at a table to eat	☐	☐
Reacts strongly to loud noises, smells, touch or tastes	☐	☐
Impulsivity *(poor self-control)*	☐	☐
History of temper tantrums	☐	☐
Does things over and over *(i.e. hand washing, lining up toys)*	☐	☐
Frustrates easily	☐	☐
Outbursts of physical aggression towards others	☐	☐
Acts like he / she is driven by a motor (boundless energy)	☐	☐
Has fears or is very afraid of things like bugs or the dark	☐	☐
Does unsafe activities like climbing on high objects and jumping off things	☐	☐
Doesn't seem to learn from experience	☐	☐

Name

Infant and Preschool Intake Form

Delivery / Birth History

Before Delivery:

Were there any drugs *(prescription or non-prescription)*, alcohol or tobacco taken during the pregnancy?

What was the biological mother's health during the pregnancy? Were there any complications such as diabetes, German measles (rubella), high blood pressure, medications?

Please indicate how much alcohol and/or drugs were used on a daily basis and also what types of drugs were used.

At what month of gestation was the pregnancy confirmed?	What was the duration of the pregnancy?

Delivery:

Please circle one: Full term Premature Overdue	Birth weight:

C-Section: No Yes	Duration of labor:	Following birth did the infant have trouble starting to breathe? No Yes

Describe any difficulties with the delivery (eg., breech birth, medications required)

After Delivery:

Was there post partum depression?

What was the mother's emotional/physical health after birth?

Child's Medical History

What is the current height and weight of this child?

Name

Infant and Preschool Intake Form

Has this child ever seen a physician for any of the following?							
☐	Ear infections	☐	Weight problems	☐	Broken bone(s)	☐	Constipation
☐	Hearing problems	☐	Feeding problems	☐	Head injury	☐	Toileting problems
☐	Vision problems	☐	Speech/language problems	☐	Sleep problems	☐	Allergies
☐	Breathing problems	☐	Seizures	☐	Experienced trauma		
☐	Other *(please describe)*						

If this child has ever been hospitalized for illness or injury, please explain why and when.

If this child has ever had surgery, please tell/explain what surgery and when.

Is this child on any medication? ☐ Yes ☐ No

If yes, what medication?

Name and phone number of current physician or pediatrician:

Developmental History

This Child as an Infant (please check)

no problems		colicky		in special nursery		Was this child:
jaundice		breathing problems		difficulty sucking		bottle fed or breast fed? *(circle one)*

Was this baby born with a congenital condition or developmental difficulties? *(please describe)*

Please indicate the age at which this child:

Walked alone	Used single words
Could identify body parts (by pointing)	Echoed/repeated words heard

Name

Infant and Preschool Intake Form

Please indicate the age at which this child:			
Followed a series of two commands (eg. pick up the toy and put it in the box)			
Speech was clear (understood by most people)		Could engage in conversation	
Bladder trained day night		Bowel trained day night	

If your child has had any of the following assessments or interventions, please mark the appropriate categories and include copies of the reports.

☐ Speech/language	☐ Occupational therapy	☐ education
☐ Psychiatry/mental health	☐ Hearing/audiology	☐ psychology
☐ Physical therapy	☐ Other:	

Family Information: Please identify parents living apart from the child:

Father's Name	☐ biological ☐ step ☐ foster	Age
In contact with the child? **No** **Yes**	If 'Yes', how often?	
Mother's Name	☐ biological ☐ step ☐ foster	Age
In contact with the child? **No** **Yes**	If 'Yes', how often?	

List all other persons (including children/teens/adults) who presently live in this home

Name	**(M /F)**	**Age**	**Relationship to Child**

List any siblings who do not live with the child

Name

Infant and Preschool Intake Form

Have the child's biological relatives had difficulties with the following?

	No	Yes	Relationship		No	Yes	Relationship
Seizures				Family violence			
Emotional problems				Hyperactivity			
Alcohol or drug problems				Sexual abuse			
Suicide				Seen a psychiatrist or counsellor			

What prompted mental health involvement now?

What have you tried to solve these problems on your own?

Do you use any of the following parenting/discipline techniques with this child?

☐ Time outs ☐ Choices ☐ Natural consequences

☐ Reward or star charts ☐ Redirection ☐ Verbal/Physical limits

School Information

Name of present preschool, daycare or day home	Age Attended	Length of Time Attended
Name of previous preschool, daycare or day home?	**Age Attended**	**Length of Time Attended**

Is this child's behavior of any concern at the pre-school, day care or day home? ☐ **No** ☐ **Yes**

If 'Yes', what were the concerns?

What does this child enjoy doing the most?

Name

Infant and Preschool Intake Form

What does this child dislike doing the most?
What do you like about this child?

Please add any other information regarding this child's behavior that you feel would be important for us to know.

Signature of the person completing this form *(parent or legal guardian)*	Date *(day-month-year)*
Relationship to child	

A signature of the alternate parent or guardian is required on this form to ensure they are aware of this request for services from CASA Child, Adolescent and Family Mental Health. A Consent to Treat will also need to be signed by both parents or legal guardians at the time of the first visit.

______________________	______________________	______________________
Signature of alternate parent or guardian	*Relationship*	*Date*

bmead/Forms/Forms 9/078C 0410