Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE

500 Church Street, Penetanguishene ON L9M 1G3
500, rue Church, Penetanguishene (Ontario) L9M 1G3
705-549-3181 www.waypointcentre.ca

Waypoint Centre for Mental Health Care

Family, Child, and Youth Mental Health Program
Parent/Caregiver Questionnaire

Instructions

FAX COMPLETED FORM AND ANY ACCOMPANYING DOCUMENTATION TO:

Waypoint Central Intake by fax to 705-549-1812 or by email to centralintake@waypointcentre.ca

Please complete this form to the best of your ability, include the following items with this questionnaire if possible:

a. A copy of the Custody agreement for your child, if applicable
b. Signed Release of Information Form
c. A copy of the most recent report card
d. Copies of occupational therapy, physiotherapy or speech therapy reports, psychological reports, psychiatric reports and school testing reports (or arrange for your family doctor to forward these if he/she has copies)

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Date: _____

FOR WAYPOINT USE ONLY	**Date Received:**		**Account #:**	

Client/Patient Information			
Name of Person Completing Form:			
Email Address:		**Consent to Email Communication:**	☐ Yes ☐ No
Name of Child/Youth (Last name, first name):			
DOB ***(dd/mm/yyyy)*****:**		**Preferred Name & Pronouns:**	
Any Other Physicians Involved (i.e., Paediatrician, Psychiatrist, etc.)?		**Issues Addressed:**	
Pharmacy:		**Drug Allergy:**	

Please describe the main concerns and behaviours which worry you: (What questions would you like answered?)

Child's Strengths: (Comment on talents, interests, skills, involvement in sports/clubs/or other activities, positive connections within the family, relatives, friends, and the community)

Main Stresses for the Child and/or Any Traumatic Events: (Have there been any major events, now or in the past, which may have been stressful to family, i.e., relocating, physical/mental illness or death, family breakdown, unemployment, violence, legal/financial problems)

How does your child cope with stress?

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How do you, as a parent/caregiver, respond to your child's distress or unexpected behaviour?

List other agencies ever involved with your child and years of involvement. Please provide note if available.

_____

_____

_____

Custody status if applicable:

☐ Joint
☐ Sole Custody
☐ Temp care agreement
☐ Other: _____
☐ Case Manager: _____

Medical

Family Doctor: _____ **Tel #:** _____

Current medications, special diets, vitamins, herbal supplements: (any over the counter) *attach list

Name and Dose	Response	Date Started / Discontinued	

Are you aware of any other assessments planned in the next 6 months? ☐ Yes ☐ No
(if yes provide the following)

When: _____ **Where:** _____ **By Whom:** _____

Significant Past or Current Health Problems:

Prenatal and Birth History and Early Development

Pregnancy Duration: _____ weeks Birth Weight: _____ Lbs _____ Ounces

Any complications during pregnancy or delivery?

_____

_____

_____

Prescription/non-prescription medication during pregnancy: ☐ Yes ☐ No

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If "Yes", please specify the medication(s):

Describe what your baby was like during the first year of life (medical/social):

Any problems encountered during the first year of life: (explain)

Child's Developmental Milestones: ☐ On track ☐ Advanced
☐ Delayed (please specify): _____

Preschool and Early Years:

Did your child attend Daycare/Preschool: ☐ Yes ☐ No

If yes, how did your child interact with other children?
If yes, did the daycare/preschool raise any concerns?

Current School:

Does your child enjoy school?
Does your child get along with teachers?
Does your child get along with classmates?
Are there any school subjects they find especially difficult?

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Past and Current Community Supports and Assessments:
Please note any details if relevant.

Occupational Therapy (OT)	
Physiotherapy (PT)	
Speech Language Therapy (SLP)	
Psychoeducational Assessment	
Community resources, etc.	
Audiology/Hearing	

Schools Attended	Grade(s)	Noted Strengths or Problems	Special Program(s)

Family History:

	Parent 1 ☐ Biological ☐ Step ☐ Foster ☐ Adoptive ☐ Other:		Parent 2 ☐ Biological ☐ Step ☐ Foster ☐ Adoptive ☐ Other:	
Name (Surname, First Name):		Age:		Age:
Mailing Address, including Postal Code:				
Phone #:				
Occupation:				
Language(s) Spoken:		Marital Status:		Marital Status:
	Current Partner:		Current Partner:	
Learning or mental health problems during school years:				
Any mental health concerns or substance use (specify):				

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Siblings: Please list all biological and stepsiblings.

Name:			Age:	Grade:	Gender:
Relationship:		Problems:			
Name:			Age:	Grade:	Gender:
Relationship:		Problems:			
Name:			Age:	Grade:	Gender:
Relationship:		Problems:			
Name:			Age:	Grade:	Gender:
Relationship:		Problems:			

Are there any physical health conditions that run in the family?
Are there any mental health conditions that run in the family?