MANITOBA FASD CENTRE
• Assessment • Education • Training • Research •

Located at: SSCY Centre
1155 Notre Dame Ave
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General Information Form

To be completed by parents/caregivers.

SSCY Centre — Specialized Services for Children & Youth

Date: _____

Child/Youth's Name: _____ Date of Birth: ____/____/____ m/d/y

MHSC#: _____ PHIN#: _____ ☐ Female ☐ Male

Name of Caregiver: _____

Relationship to Child/Youth: ☐ Birth Parent ☐ Adoptive Parent ☐ Other _____

Caregiver's Address: _____ City: _____

Postal Code: _____ Home or Cell Phone: _____ Work Phone: _____

Legal guardian's name if different from caregiver: _____

Who wants this FASD assessment? _____

Name of person filling out this form: _____

Your relationship to Child/Youth being referred: _____

Phone: _____ Fax: _____ *Email:* _____

Who is your child's doctor? _____

Please list what your child/youth is good at and what do they like to do:

_____

_____

_____

Please list the child/youth's current issues and concerns:

_____

_____

_____

Is there anyone else seeing your child/youth? _____

Previous Assessments

Has the child/youth been seen by:

	Name of Person & Phone Number	Date (s) of Assessment	Report Attached &/or Currently Seeing
☐ MB FASD Centre			☐ Report Attached ☐ Currently Seeing
☐ Child Development Clinic			☐ Report Attached ☐ Currently Seeing
☐ Genetics			☐ Report Attached ☐ Currently Seeing
☐ Occupational Therapist			☐ Report Attached ☐ Currently Seeing
☐ Physiotherapist			☐ Report Attached ☐ Currently Seeing
☐ Psychologist			☐ Report Attached ☐ Currently Seeing
☐ Psychiatry / Mental Health Worker			☐ Report Attached ☐ Currently Seeing
☐ Speech Language Pathologist			☐ Report Attached ☐ Currently Seeing
☐ Other			☐ Report Attached ☐ Currently Seeing

Developmental and/or Behavioral Concerns

Comments

Has the child/youth had any problems with?

☐ Use of large muscles like running, walking, climbing _____
☐ Use of hands and feet, printing or writing _____
☐ Understanding instructions _____
☐ Very active, hard to focus _____
☐ Feeling good about themselves? _____
☐ Bed wetting or soiling _____
☐ How your child gets along with other children? _____
☐ Growth (Have you been worried about your child's growth? _____
☐ Feeding (Drinking, chewing or swallowing food)? _____
☐ How does your child respond to noise, lights, touch or movement? _____
☐ Sleeping (settling for sleep, sleeping through the night)? _____
☐ Alcohol and drug use _____
☐ Running away _____
☐ Self Harm (Cutting) _____
☐ Breaking the law _____
☐ Has your child ever been exposed to trauma such as physical, emotional or sexual abuse or other stressful events?
____ yes ____ no

Briefly describe:

_____

_____

Medical History

In the past, has your child had the following?

- Major Illnesses or medical problems ☐ Yes ☐ No ☐ Unknown
  Describe:_____
- Spent time in Hospital ☐ Yes ☐ No ☐ Unknown
  Describe:_____

Please list any medicines that the child/youth is taking:

_____

_____

Please list the child/youth's brothers and/or sisters:

_____

_____

_____

_____

_____

Please list family in your home:

_____

_____

_____

_____

_____

Prenatal History

Was alcohol used in the pregnancy?

First 3 months of the pregnancy?	☐ Yes	☐ No	☐ Suspected	☐ Unknown
4 to 6 months of the pregnancy?	☐ Yes	☐ No	☐ Suspected	☐ Unknown
7 to 9 months	☐ Yes	☐ No	☐ Suspected	☐ Unknown

Average number of drinks on each occasion: _____ Maximum number of drinks on each occasion: _____

How many times of drinking occasions each week: _____

Who gave this information? _____

Comments:_____

_____

_____

Was the following also taken during this pregnancy?

Marijuana (pot/weed)	☐ Yes	☐ No	Cocaine	☐ Yes	☐ No
Solvents	☐ Yes	☐ No	Prescription Drugs	☐ Yes	☐ No

Other, please list: _____

Form completed by: (please print)

Name(s): _____ _____

Thank you for completing this form.