Macdonald Psychological Services
complexlearners.com

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CLIENT INFORMATION

Client's Name:	Date:
Form Completed by:	Date of Birth:
Relationship to Client:	Who does the client live with?

SIBLINGS		
Name	**Age**	**Sex**

PREGNANCY AND DELIVERY	
Full Term Pregnancy Y/N	If no, number of weeks at delivery?
Complications Y/N	If yes, please describe briefly
Post care supports for child, if any	

DEVELOPMENTAL MILESTONES				
MILESTONES	**DELAYED**	**TYPICAL**	**ADVANCED**	**COMMENTS**
Talking				
Fine/Gross Motor				
Social Interactions				

GENERAL HEALTH AND DEVELOPMENT Briefly Describe:		
Sleep Problems	Y/N	
Eating Problems	Y/N	
Temper Tantrums	Y/N	
Excessive Crying	Y/N	
Separation anxiety/ fears	Y/N	

MEDICAL HISTORY (comments)		
	YES/NO	**Comments**
Any Childhood Illness	Y/N	
Injuries	Y/N	
Head injuries/Concussion	Y/N	
Operations	Y/N	

Speech Difficulties	Y/N	
Accident Prone	Y/N	
Allergies	Y/N	
Hearing Issues Date of most recent hearing test	Y/N	
Vision Issues Date of most recent vision test	Y/N	
Medications	Y/N	

FAMILY HISTORY		
Have any family members had any of the following:	**YES/ NO**	**Comments:**
Behaviour Disorder	Y/N	
Emotional Disturbance	Y/N	
Anxiety	Y/N	
Depression	Y/N	
Seizures or Epilepsy	Y/N	
Reading difficulties	Y/N	
Other learning disability	Y/N	
Has the child experienced any parental separation/ divorce/ death?	Y/N	

PREVIOUS ASSESSMENTS	Psychologist/Date/City
Any previous psychological assessments? (please ensure report is made available to MPS)	

Areas of Interest(s)	Nature of Activities	Approx. hrs./ day or week
Sports/ Athletics		
Fine Arts		
Organized activities (church groups/ Scouts/ Guides, etc.,)		
Screentime (gaming, browsing, social media, video, etc.)		
Other		

School and School Readiness		
Demonstrate difficulty with reading	Y/N	
Demonstrate difficulty with math	Y/N	
Demonstrate difficulty with writing	Y/N	
Positive attitude toward school	Y/N	