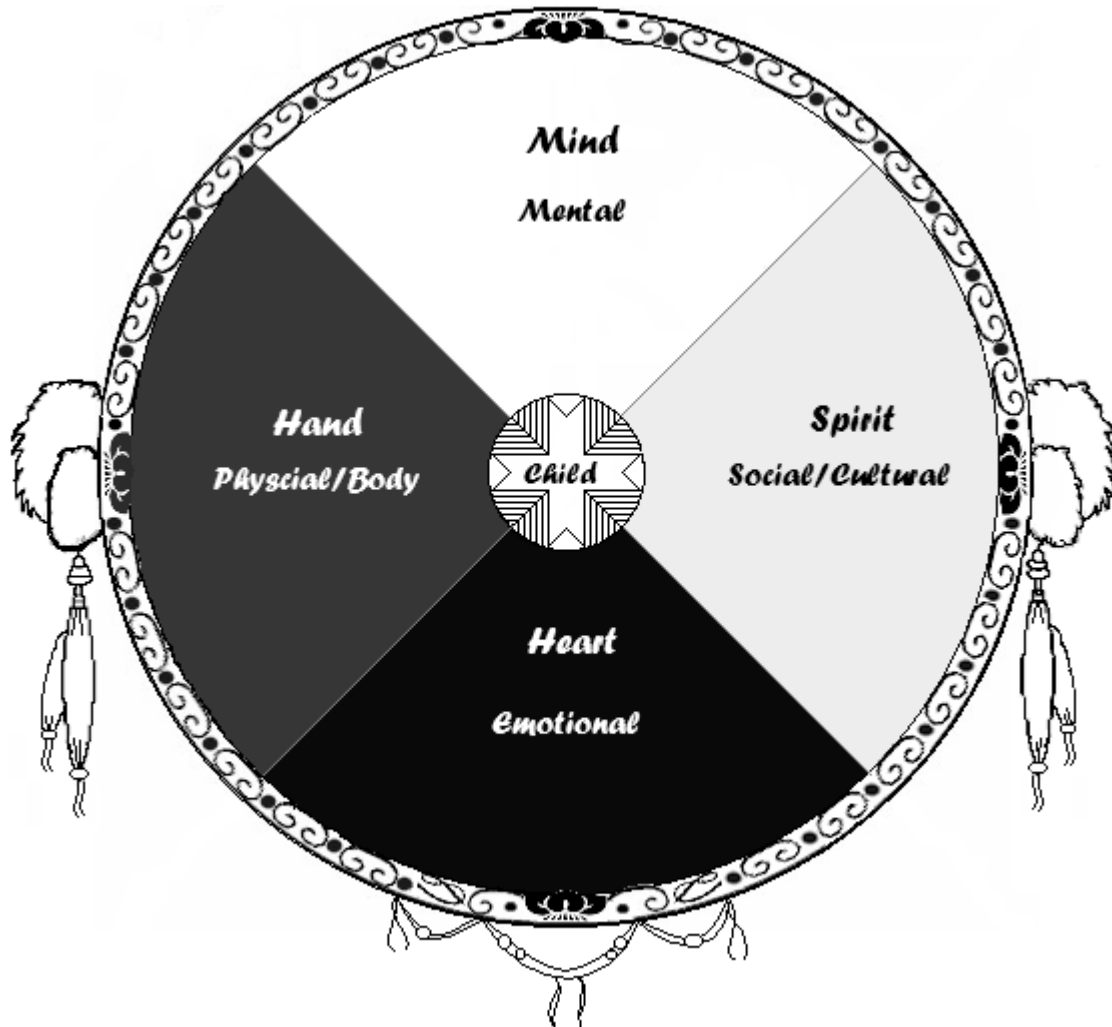


Medicine Wheel Developmental History



Person Taking History: _____

Person Giving History: _____

Relationship to Referred Person: _____

Date: _____

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Please Call: Elsipogtog First Nation School (506.523.8142) If you Find This Tool Helpful or For More
Information about How To Use.

The Center ~ The Child



1. Child's Name: _____ Medical #: _____ Sex _____
 Date of Birth: _____ Place of Birth: _____

2. Child's Family Doctor

Name: _____
 Address: _____
 Telephone: _____

3. Parents-Fill All That Is Applicable

	Birth Mother	Birth Father	Guardian
Name			
Birth Date			
Education Level			
Occupation			
Home Telephone			
Work Telephone			
Home Address			

	Adoptive Mother	Adoptive Father	Foster Mother	Foster Father
Name				
Birth Date				
Education Level				
Occupation				
Home Telephone				
Work Telephone				
Home Address				

Notes



PRESENT PROBLEMS

1. Briefly describe the child's current difficulties.

2. How long has this been of concern to you?

3. What seems to help the problem or make it worse?

4. Has the child had any evaluation or treatment for these or other problems?

Yes _____ No _____

5. If yes, when and with whom? _____

6. Has the child been examined by any of the following specialists? If any problems were found, please specify under results.

Specialists	No	Yes	Name of Professional	Place	Results
Audiologist (hearing)- a.					
Ophthalmologist or Optometrist (vision) – b.					
Neurologist – c.					
Neuropsychologist –d.					
Allergist – e.					

The Center ~ The Child



7. Does your child wear glasses? Yes No Hearing Aid? Yes No
8. Is the child on any medication at this time? Yes _____ No _____
9. If yes, please note the kind of medication. _____

10. What are your child's favourite activities?
a. _____ b. _____ c. _____
d. _____ e. _____
11. What activities does your child like least?
a. _____ b. _____ c. _____
12. What are your child's strengths or special gifts? In school? Out of school?

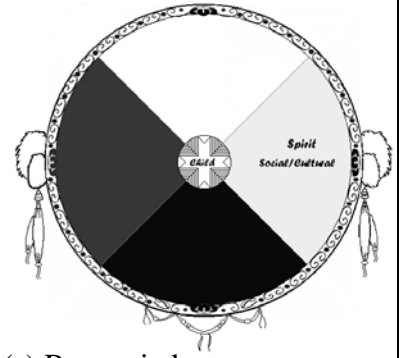
Agency Involvement

Has the child ever been involved with the following community agencies?

Agency	No	Yes	When	Reason
a. Mental Health/Psychological Services				
b. Child & Family Services				
c. Police/R.C.M.P.				
d. Drug and Alcohol				

Notes

Eastern Direction ~ Social History



1. Parent's marital Status:

a. _____ Single	_____	_____ Parent(s) Remarried
b. _____ Married	_____	
c. _____ Separated	_____	
d. _____ Divorced	_____	
f. _____ Common-Law	_____	

2. If parents are separated, how old was child when separation occurred? _____

3. Child lives primarily with

a. _____ Mother

b. _____ Father

c. _____ Both parents

d. _____ Other (please name) _____

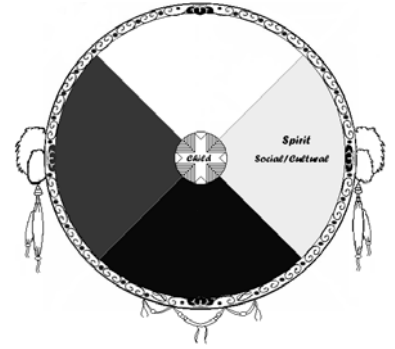
4. Number of brothers and sisters: _____

5. Please List

Name of Sibling (oldest to youngest)	Birth Date	Age	Grade	Living Home

Notes

Eastern Direction ~ Social History



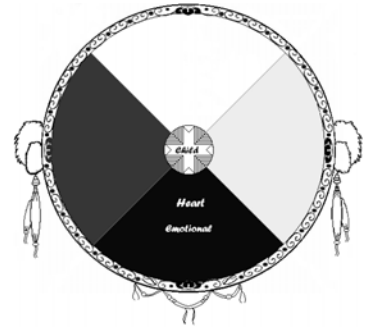
6. List all people living in household aside from immediate family

Name	Relationship to Child	Age

Cultural-Linguistic Background

7. What is the first language of:
 a. mother _____ b. father _____ c. child _____
8. Which languages are used between:
 a. mother & father _____ c. father & child _____
 b. mother & child _____ d. siblings & child _____

Notes



TRAUMA - ABUSE

1. Do you think your child might drink? _____
2. Do you think you child might sniff? _____
3. Do you think your child might do any kind of drugs? _____
4. Do you think your child might smoke cigarettes? _____
5. Are you concerned your child may have been sexually abused? _____
6. Are you concerned your child may have been physically abused? _____

SUICIDE & GRIEF

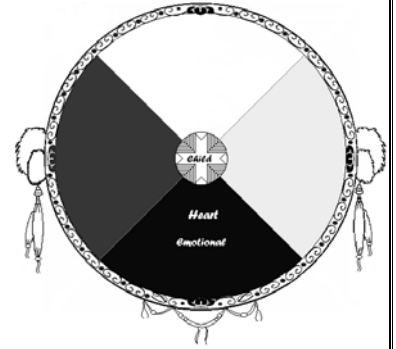
1. Has your child ever talked about suicide? _____ When? _____
2. Has he/she even attempted suicide? _____
3. Has your child ever hurt itself on purpose? _____
4. Has anyone in your family attempted suicide or died recently? _____
5. Has anyone in your family died during the child's life? _____ When? _____

ATTACHMENT

1. Does your child have a special relationship with someone in your family (Grandparent, Auntie, Godparent)? Yes _____ No _____
2. If yes, with whom? _____
3. Has the child had multiple placements? _____
4. How many? _____ 5. List Placements

With Whom?	How Long?

Notes

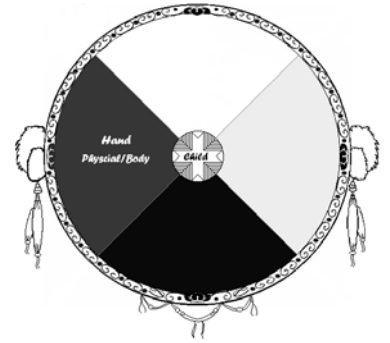


SOCIAL BEHAVIOR CHECKLIST

Place a check next to any behavior or problem that you child currently exhibits.
Mild 1, Moderate 2, Severe 3

- Has frequent tantrums
- Has frequent nightmares
- Has trouble sleeping
- Does not get long well with siblings
- Always the Bully
- Eats poorly
- Is aggressive
- Is stubborn
- Is shy or timid
- Depressed, Sad, Withdrawn
- Defiant, Angry
- Lies, Steals or Destroys Things
- Has poor bowel or bladder control
- Is more interested in things (objects) than in people
- Engages in dangerous or daredevil behavior
- Hurts Animals or People On Purpose
- Anxious, Has special fears, or mannerisms
- Gives up easily
- Bites nails
- Other—Name _____

Notes



Genetic Background-Family History of Problems

1. Please indicate if anyone in the family has:
- 2.

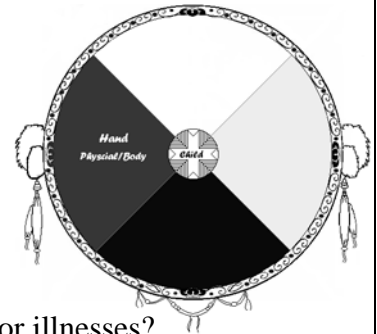
Problem	Mother (a)	Father (b)	Brothers (c)	Sisters (d)	Mother's Family (e)	Father's Family (f)
1. Trouble learning to spell or read						
2. Trouble with arithmetic						
3. Speech or language problems						
4. Repeated Grade(s)						
5. Been diagnosed as hyperactive						
6. Been diagnosed with learning/developmental disabilities						
7. Had other developmental difficulties (specify)						

Family Medical History

Place a check next to any illness or condition that any member of the immediate family has had. When you check an item, please note the member's relationship to the child.

<i>Check</i>	<i>Condition</i>	<i>Relationship to Child</i>
_____	Alcoholism (a)	_____
_____	Diabetes (b)	_____
_____	Heart trouble (c)	_____
_____	Nervous / psychological problem (d)	_____
_____	Depression (e)	_____
_____	Suicide attempt (f)	_____
_____	Other _____ (g)	_____

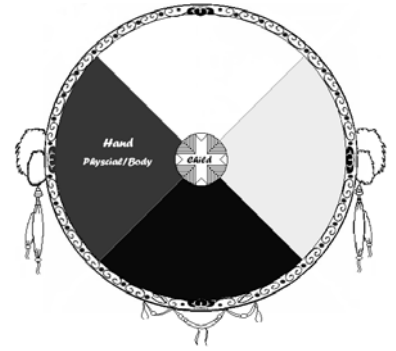
Notes



Medical Conditions

1. Has the child ever had any serious diseases, accidents, operations, or illnesses? Please specify (i.e. loss of consciousness, convulsions, allergies, repeated ear infections, etc.)

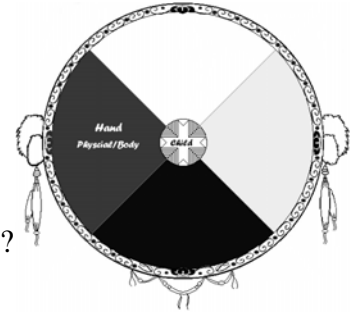
Check	Illness or Condition	Date(s) or Age
_____	Measles – a.	_____
_____	German measles – b.	_____
_____	Mumps – c.	_____
_____	Chicken pox – d.	_____
_____	Whooping cough – e.	_____
_____	Diphtheria – f.	_____
_____	Scarlet fever – g.	_____
_____	Meningitis – h.	_____
_____	Encephalitis – i.	_____
_____	High fever – j.	_____
_____	Convulsions – k.	_____
_____	Allergy – l.	_____
_____	Hay fever – m.	_____
_____	Injuries to head – n.	_____
_____	Broken bones – o.	_____
_____	Hospitalization – p.	_____
_____	Operations – q.	_____
_____	Fainting spells-loss of consciousness – r.	_____
_____	Paralysis – s	_____
_____	Ear problems (disease, impaired hearing)-t	_____
_____	Dizziness – u	_____
_____	Frequent or severe headaches – v.	_____
_____	Memory problems – w.	_____
_____	Epilepsy – .x	_____
_____	Anemia – y	_____
_____	Jaundice/hepatitis – z	_____
_____	Diabetes – aa	_____
_____	Cancer – bb	_____
_____	Heart disease – cc	_____
_____	Asthma – dd	_____
_____	Other –ee	_____



DEVELOPMENTAL HISTORY

1. **PREGNANCY HISTORY**

- a. During pregnancy, was mother on medication? Yes _____ No _____
- b. If yes, what kind? _____
- c. During pregnancy, did mother smoke? Yes _____ No _____
- d. If yes, how many cigarettes each day? _____
- e. During pregnancy, did mother drink alcoholic beverages? Yes _____ No _____
- f. Did she drink before she knew she was pregnant? Yes _____ No _____
- g. If yes, what did she drink? _____
- h. Approximately how much alcohol was consumed each day? _____
- i. During pregnancy, did mother use drugs? Yes _____ No _____
- j. Did she before she knew? Yes _____ No _____
- j. If yes, what kind? _____
- k. Were forceps used during delivery? Yes _____ No _____
- l. Was a Caesarean Section performed? Yes _____ No _____
- m. If yes, for what reason? _____
- n. Was the child premature? Yes _____ No _____
- o. If so, by how many months? _____
- p. Were there any birth defects or complications? Yes _____ No _____
- q. If yes, please describe. _____
- r. What was the child's birth weight? _____
- s. Mother's age at birth? _____



2. **NEONATAL HISTORY AND INFANCY**

A. Did the following problems occur during the first few weeks of life?

Problem	No	Yes	Comments
Placed in incubator – a.			
Blood transfusions – b.			
Jaundice – c.			
Problems breathing – d.			
Problems feeding – e.			
Convulsions – f.			
Other (specify) – g.			

B. Did the baby leave the hospital with the mother?
 _____ yes _____ no comments: _____

C. Did the baby have colic?
 _____ yes _____ no comments: _____

D. As an infant did the child like to be held?
 _____ yes _____ no comments: _____

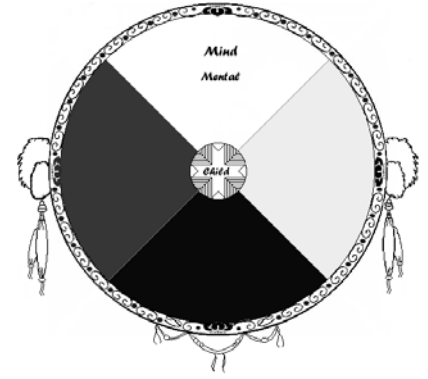
E. Was the child alert as an infant?
 _____ yes _____ no comments: _____

F. In general, how would you best describe your child's behaviour during the first 2 years of life?
 _____ easy – a. _____ slow to adjust –c.
 _____ difficult –b. _____ Other – d. _____

G. Were there any special problems in growth ? _____

Notes

Northern Direction ~ Mental -Cognitive Development



DEVELOPMENTAL MILESTONES

1. At what age did the child do the following:

Behaviour	Age	Age
a. Rolled over		g. Babbled
b. Sat alone		h. Spoke first word
c. Crawled		i. Put several words together
d. Walked alone		j. Fed self
e. Rode tricycle		k. Became toilet trained
f. Dressed self		l. Stayed dry all night

NEUROBEHAVIOR CHECKLIST

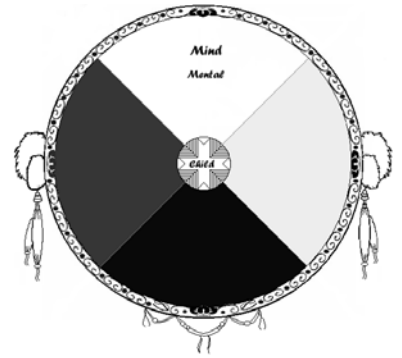
2. Place a check next to any behavior or problem that you child currently exhibits.

Check	Problem
<input type="checkbox"/>	Has difficulty with speech -a
<input type="checkbox"/>	Has difficulty with hearing-b
<input type="checkbox"/>	Has difficulty with language-c
<input type="checkbox"/>	Has difficulty with vision-d
<input type="checkbox"/>	Has difficulty with coordination-e
<input type="checkbox"/>	Is clumsy-bumps into things-f
<input type="checkbox"/>	Has blank spells-g
<input type="checkbox"/>	Is slow to learn-h
<input type="checkbox"/>	Rocks back and forth-i
<input type="checkbox"/>	Over-Active (Compared to Other Children Same Age)-j
<input type="checkbox"/>	Under-Active(Compared to Other Children Same Age)-k
<input type="checkbox"/>	Impulsive (Doesn't Think Before Acting)-l
<input type="checkbox"/>	Short Attention Span (Flits From One Thing To Another)-m
<input type="checkbox"/>	Poor Memory-n
<input type="checkbox"/>	Difficulty Organizing-m
<input type="checkbox"/>	Difficulty Understanding Concept of Time-n

3. Which hand does the child use for writing? a. left b. right c. both

4. Which hand is used for other activities? a. left b. right c. both

Northern Direction ~ Mental -Cognitive Development



SCHOOL HISTORY

- Has your child ever been left back in school? Yes _____ No _____
 Grade _____ Grade _____
 Grade _____ Grade _____
- Has your child ever been expelled or suspended from school ?
 Never _____ A Few Times _____ Frequently _____ Is Now Suspended or Expelled _____

PROBLEM AREAS

Please indicate if the child has had

Problem	<i>Never Problem</i>	<i>Present Problem</i>	<i>Past Problem</i>			
1. trouble learning to read or spell						
2. trouble with arithmetic						
3. general academic problems						
4. behavior problems						
5. other school problems-Name						
6. liking school						

PREVIOUS ASSESSMENTS AND TREATMENTS

- Provide the following information concerning assessments received by your child (Attach reports if possible).

Assessments	No	Yes	Date	Age	Place	Name of Professional
2. Educational						
3. Sensory-Motor						
4. Speech-Language						
5. Occupational Therapy						
6. Other _____						

Parenting-For Children With Behavioral Problems-Optional



5. What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually see. There also is a space for writing any other disciplinary techniques that you use.

Check	Parenting Techniques
_____	Ignore problem behaviour – a.
_____	Scold child – b.
_____	Spank child – c.
_____	Threaten child – d.
_____	Reason with child – e.
_____	Redirect child’s interest – f.
_____	Tell child to sit on chair – g.
_____	Send child to his/her room – h.
_____	Take away some activity or food – i.
_____	Other technique (describe) _____ -j.
_____	Don’t use any technique – k.

What disciplinary techniques are usually effective? _____

With what type of problem(s)? _____

Which disciplinary techniques are usually ineffective? _____

With what type of problem(s)? _____

What have you found to be the most satisfactory ways of helping your child?

