MENTAL RETARDATION CENTRE
2 Surrey Place,
TORONTO 5, Ontario
Phone: 365-5111

Name of person filling in form: [redacted]

Relationship to child: worker

Child's name: [redacted] [redacted]
Surname First Other

Address: Sunbeam Home Waterloo
Street City/Town Municipality County

Sex: Male: X Female: ___ Date of birth: [redacted] 19[redacted], Age: [redacted]

Next of Kin:
NAME: Children's Aid Society of Metro. Toronto

Address: 33 Charles St. E.

Telephone No: ___ 924-4646 ___
Home Office Other

Religion of Child: Protestant Baptized or Confirmed: Yes ___ No X

Country of Birth: Canada

In Canada since: ___ Ontario ___ Municipality ___
year

Present School:
Name: ___ Address: ___

Telephone No: ___ Principal's Name: ___

Teacher's Name: ___ Not in School ☐

If employed type of work ___

Not employed: ☐

ADMINISTRATOR
SEP 26 1968
MENTAL RETARDATION CENTRE

Referred to Centre By:

Name: [redacted]

Address: 33 Charles St. E.
Tor 5

Telephone No: 924-4646

Family Doctor:

Name: [redacted]

Address: 33 Charles St E.

Telephone No: 924-4646

Ontario Hospital Insurance Commission (O.H.S.C.) # [redacted]
Ontario Medical Services Insurance Plan (O.M.S.I.P.) # [redacted]
Other Medical Insurance # ___

What are your reasons for wishing to have your child seen in the Retardation Centre? (List problems):

List any schools, hospitals, clinics, or private practitioners, who have examined or been active with your child for mental retardation, with dates and addresses.

Does your Public Health Nurse visit you about your child? Yes:_____ No:_____

Name:_____ Address:_____

List any other persons (other than in school) who regularly help to care for your child:

Has child always lived with you: Yes: _____ No:_____

If no, where and when:

What is the main language spoken at home? _____

Does child understand English? Yes:_____ No:_____

Does child speak English: Yes:_____ No:_____

Do parents understand and speak English? Yes:_____ No:_____

Does child share room? Yes____ No_____. If yes, with whom? _____

Does child share bed? Yes_____ No_____. If yes, with whom? _____

Are both natural parents living in the home at present? Yes:_____ No:_____

List others living with family:

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Father

Full Name [redacted]

Date of Birth August 1930

s. 21(1) and s. 49(b)

Religion

Address

Country of Birth England

Nationality of Ancestors English

Date of entry into Canada, if not Canadian born 1951

Canadian Citizen? Yes ? No

Highest grade completed at School XII

Age 14½ yrs.

Further education? Yes No (Describe)

Present occupation Truck Driver

Yearly income before deductions

Date of marriage April 7, 1953

Have you been married before? Yes No X

Are you in good Health? Yes X No

Have you ever suffered from mental or emotional illness? Yes X. No

"Schizoid Personality"

If dead, cause of death and date

MENTAL RETARDATION CENTRE

Mother

Full Name [redacted]

Date of Birth March 7, 1927

s. 21(1) and s. 49(b)

Religion

Address

Country of Birth U.S.A.

Nationality of Ancestors Irish

Date of entry into Canada, if not Canadian born

Canadian citizen? Yes .No

Highest grade completed at school 6/11
Age 15 yrs 6 yrs

Further education? Yes No
Describe:

Present Occupation housewife

Yearly Income before deductions

Date of marriage April 7/1951

Have you been married before? Yes No
Are you in good health? Yes X .No

Have you ever suffered from mental or emotional illness? Yes X .No
Para. Schizophrenia

If dead, cause of death and date

Brothers and Sisters

List in order of each pregnancy living or dead, starting with the first; include children from other marriages, if any; include miscarriages, stillbirths and deaths:

Name	Date of Birth	Present health if living or cause of death and age	Present grade or highest grade completed and age
(self) [redacted]	March 1947	s. 21(1) and s. 49(b)	s. 21(1) and s. 49(b)
	Jan. 1954		
	7 wks 2/15		
	Sept 1958		
Twins [redacted]	Oct, 1959		
	May, 1962		

Pregnancy and Delivery

1)Do any of the following apply to when you were pregnant with the patient? (Please Tick)

Illnesses or operations ____:, In contact with German Measles ____:, Skin rashes ____:, X-rays in first three months ____:, Smoke ____:,if yes, how much ____:, Serious emotional stress____, Take Thyroid ____:, Anti-nausants____:, Diuretics ____, Hormones____, Cortisone____, others, state ____:, Vaginal bleeding or spotting ____:, Special diet: low salt____, low calorie ____, other, specify_____:, Weight gain _____pounds; swelling of ankles____, hands____; Severe nausea and vomiting_____:, Severe headaches_____:, Fainting spells or dizziness_____:, Increased blood pressure_____:, Heart trouble____:, Kidney trouble_____:, Thyroid trouble_____:, Diabetes_____:, In bed a lot____:, Other unusual occurrences_____, if yes, specify_____ _____.

2)What month of pregnancy did you first see a doctor?_____.

3)How many times did you see him?_____

4)Are the mother and father blood relatives? Yes_____. No____. If yes, what relationship? _____.

Labour and Delivery

1)Hospital of Birth,Name and Place_____ No. Mt Sinai Hospital, Toronto

2)Age at time of birth, Mother 34 yrs Father 34 yrs

3)Did child arrive on expected Date? Yes_X_ No_____ Days early____ Days late_____

4)How many hours was the labour? ?_____.

5)Did water break before labour ?_____, during labour ?_____, at time of birth _____.

6)Did your doctor bring on labour?Yes ?_____ No_____

Describe here any abnormalities

Normal Pregnancy

Labour and Delivery(Cont'd)

Describe here any abnormalities

7) Was baby held back? Yes___ No___
8) Was child born: head first___
breech___ other, specify_____
caesarian, specify_____
9) Were you given anything to ease labour pains? Yes___ No___
10) When baby was born were you:wide awake___ Half awake___ Unconscious___
11) Did mother receive a blood transfusion? Yes___ No___
12) Blood Group: Mother Father
RH positive _____ _____
RH negative _____ _____
Type O or A _____ _____
or AB or B _____ _____
13) Describe anything of importance in labour or delivery not covered. _____

First Week of Life

1) Birth weight ___lbs. ___oz.
2) How soon after birth did you see child? _____.
3) Did he cry immediately on birth? Yes___ No___
4) Did he go into an incubator?Yes___No___
If yes, how long?_____
5) Did he have any of the following:
A weak cry_____. Overly placid_____
Blue Spells _____. Jaundiced (yellow) skin_____ Bruised head or face_____
Head out of shape_____. Did not move all his limbs well _____. Did not suck well _____. Receive a transfusion_____
Twitching movements _____ Convulsions _____. Other abnormalities_____
6) How many days were you in hospital? was child_____.

First Year

1) Were there any feeding problems in first year? Yes___. No___
2) Solid food started at age _____
3) Did child: Gain weight well_____
Vomit a lot_____ Diarrhoea a lot_____
Cry a lot_____ Sleep Poorly_____
Have trouble swallowing_____ Overly placid _____ Overly active_____
Other abnormalities_____

Development

1) When did you first suspect child was retarded, and why? child admitted to care at 4yrs 6 placed directly in Sunbeam Home

2) When were you first professionally told child was retarded, and by whom? H.S.C. - 1963

3) At what age did child:- Walk 3½ yrs Express wants verbally delayed Feed Self n.d. Toilet trained day n.d. Toilet trained night n.d. Dress self n.d. Tie shoes n.d. Ride tricycle n.d. Ride bicycle n.d.

Handling Basic Needs

1.) Child eats expected amounts for his age? Yes ? No

2.) Child eats same diet as family? Yes ? No . If no, describe

3) Hours of sleep per night ?

4) Sleeps soundly? Yes ? No

5) Rest during day? Yes ? No

6) Girl:- Has she had any periods? Yes No .
Age at onset of periods .
Regular, Yes No
Problems, Yes No . If yes, describe,

7) Do you have any concerns about your child and sexual matters? Yes No
If yes, describe

Handling of Social Needs

1) Opportunity to make friends? Yes yes No

2) Has continuing friends or playmates? Yes No no

3) Average age of friends .

4) Describe any difficulties he has with other children
no relationships

With brothers and sisters:

Handling and Social Needs (cont'd)

Describe here any abnormalities

5) Is child: Overactive___ Underactive X
Shy___ Rocks___ Head bangs___
Fearful___ Jealous___ Thumb sucking
___Destructive___ Temper Tantrums___
Nightmares___ Distractible___
Clumsy___. autistic

6) When both parents present, who is principle disciplinarian? Mother___
Father___ Both___.

7) Do parents generally agree on discipline?
Yes___ No___.

8) Child's favourite pastimes are:

Education

1) Age when started school___.

2) Is child in school? Yes___ No X If no, why? Too retarded + unstable

3) List schools or nursery schools attended:

	Year	Name	Present
A)			
B)			
C)			
D)			

4) Describe any difficulties at school:

Admissions to Hospital

Reason	Age	Hospital
1) None known		
2) Seen as out patient at west end		
3)		
4)		

Illnesses none Age

Measles___ German Measles___
Mumps___ Chicken Pox___
Scarlet Fever___ Pneumonia___
Meningitis___ Other___
Serious Accidents___

Admissions to Hospital (Cont'd)

Describe here any abnormalities

Immunization and Vaccination (list with Dates)
given at Sunbeam Home

Functional Inquiry

1) Child had convulsions? Yes___ No X
Age at first convulsion_____
Date of last seizure _____
In last year, number of seizures_____

2) Names of any medications at present on, with dose None X
a) _____
b) _____
c) _____

3) Does child have:
Weakness of one or both arms no
Weakness of one or both legs no
Frequent ear infections no
Poor Hearing ? Poor Vision ?
Crossed eyes ? Eyes that turn out _____ Frequent colds _____
Difficulty swallowing no
Poor teeth ? Indistinct speech _____
Abnormal swellings ? Breast development no Shortness of breath no Heart trouble _____
Heart murmurs no Blue spells no
Diarrhoea no Constipation no
Odd smelling urine no Odd coloured urine no Skin rashes no
Swollen joints no Walks poorly no
Runs poorly no Other physical problems (describe) _____

General Family History

1) Is there anyone in either side of child's family including parents, brothers, sisters, aunts, uncles, grand-parents, cousins etc who has or was:
a) Mentally retarded or slow? Yes X No ___
Describe ? Brothers + Sisters

b) Epilepsy? Yes___ No X Describe.

c) Born with physical abnormalities?
Yes___ No X Describe: _____