[redacted]

METRO ORIENTATION CENTRE
2 Surrey Place
TORONTO 5, Ontario
Phone: 925-5141

Name of person filling in form: Miss [redacted]

Relationship to child: Social Worker

Child's Name: [redacted]
Surname First Other

Address: [redacted] KITCHENER ONTARIO
Street City/Town Municipality

Sex: Male: ✓ Female: ___ Date of birth: [redacted] 1961, Age: 11 [redacted]

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

Address: 33 Charles St. East TOR 5 Ontario

Telephone No: ___ 924-4646 ___
Home Office Other

Religion of Child: PROTESTANT Baptized or Confirmed: Yes___ No___

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: ✓

Referred to Centre by:

Name: Metro Children's Aid Society

Address: 33 Charles St E
Toronto Ontario

Telephone No: 924-4646

Family Doctor:

Name: DR [redacted]

Address: 33 Charles St E
Toronto Ontario

Telephone No: 924-4646

Ontario Health Insurance Commission # 0111 [redacted]

Other Medical Insurance # ___

Page 2. MENTAL RETARDATION CENTRE

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

Child has been diagnosed as being severely retarded with autistic symptoms

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

Dr. [redacted], Clinic [illegible] Hospital [illegible] (July [illegible])

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: [illegible]

What is the main language spoken at home? English

…s 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? with other children [illegible]

Does child share bed? Yes ______ No ✓ If yes, with whom? ______

Are both natural parents living in the home at present? Yes: ______ No: [illegible]

List others living with family:

1 Sibling [illegible] born September 23, 19[illegible]

[redacted]

Father

Full Name [redacted]

Date of Birth [redacted] 1930

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

Religion _____

Address Not applicable

Country of Birth KENT, ENGLAND

Nationality of Ancestors ENGLISH

Date of entry into Canada, if not Canadian born 1951

Canadian Citizen? Yes ✓ No _____

Highest grade completed at School XIII Age 14½.

Further education? Yes ___ No ✓ (Describe) _____

Present occupation Not applicable

Yearly income before deductions _____

Date of marriage April 7 1953

Have you been married before? Yes ___ No ✓

Are you in good Health? Yes ___, No _____

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

If dead, cause of death and date _____

MENTAL RETARDATION CENTRE

Mother

Full Nam[redacted]

Date of [redacted] 19.27

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

Religion

Address not applicable

Country of Birth HOWICELL, N.Y. 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 VII
Age 16 .

Further education? Yes No ✓
Describe:

Present Occupation not applicable

Yearly Income before deductions

Date of marriage APRIL 7, 1953
Have you been married before? Yes No ✓
Are you in good health? Yes .No

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

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
[redacted]	[redacted]		

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_____

Describe here any abnormalities

DO NOT KNOW

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_____
WELLESLEY HOSPITAL

2)Age at time of birth, Mother 31
Father 31

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

4)How many hours was the labour?_____.

5)Did water break before labour____, during labour_____, at time of birth_____.

DO(KNOWN

6)Did your doctor bring on labour?Yes____
No

MENTAL RETARDATION CENTRE.

Describe here any abnormalities

Labour and Delivery(Cont'd)

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 7 lbs. 3 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? March 1962 Child did not respond to stimulation. He preferred to be alone and would cry if approached or handled.

2) When were you first professionally told child was retarded, and by whom? October 1963, DR [redacted]

3) At what age did child:- Walk 3½ yrs Express wants verbally No Feed Self Yes. Toilet trained day No Toilet trained night No Dress self Yes Tie shoes No Ride tricycle No Ride bicycle No

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 Child to get diet of regular cereal foods.

3) Hours of sleep per night 11 hrs
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 No ✓
2) Has continuing friends or playmates? Yes No ✓.
3) Average age of friends .
4) Describe any difficulties he has with other children He is friendly towards other children but does not go out of his way to make friends
With brothers and sisters: Does not recognize his own family.

Handling and Social Needs (cont'd)

5) Is child: Overactive ✓ Underactive ____
Shy ____ Rocks ____ Head bangs ____ Fearful ____
Jealous ____ Thumb sucking ____ Destructive ____
Temper tantrums ✓ Nightmares ____ Distractible ____ Clumsy ____

6) When both parents are present, who is the principal disciplinarian? Mother ____
Father ____ Both ____

7) Do parents generally agree on discipline?
Yes ____ No ____

8) Child's favourite pastimes are: Playing by himself, listening to music and singing

Education

1) Age when started school ____

2) Is child in school? Yes ____ No ____ If no, why? ____

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)		
2)		
3)		
4)		

Illnesses

	Age		Age
Measles		Meningitis	
Scarlet Fever		Pneumonia	
German Measles		Mumps	
Chicken Pox		Other	
Serious Accidents			

Describe here any abnormalities

MENTAL RETARDATION CENTRE

Admissions to Hospital (con't)

Describe here any abnormalities

Immunization and Vaccination (list with dates):

Functional Inquiry

1) Has child had convulsions? Yes_____
No ✓ 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
a) Nozinan 10 mgs BID
b) Mellaril 50 mgs qhs PRN
c)_____

3) Does child have:

Weakness of one or both arms_____
Weakness of one or both legs_____
Frequent ear infections_____Poor Hearing_____Poor Vision_____Crossed Eyes_____Eyes that turn out_____Frequent Colds_____Difficulty swallowing_____
Poor Teeth_____Indistinct Speech_____ No Speech
Abnormal swellings_____Breast development_____Shortness of Breath_____
Heart trouble_____ Heart murmurs_____
Blue Spells_____Diarrhoea_____Constipation_____Odd-smelling urine_____
Skin rashes_____Swollen Joints_____
Walks poorly_____Runs poorly_____
Other physical problems (describe)_____

General Family History

1) Is there anyone on 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 ✓ No_____
Describe Both sister's Have and Karen are retarded in Quite

b) Epilepsy? Yes_____No_____Describe:

c) Born with physical abnormalities? Yes_____
No ✓ Describe_____