Agoo services familiaux et scolaires
3230 Boulevard Curé-Labelle #305,
Laval, QC H7P 0H9
450-687-6888 ext. 113
fss@agoomd.com

Developmental History

Below are a series of questions pertaining to your child's past and current developmental history. We thank you for taking the time to answer all questions to the best of your knowledge. Please note that the information provided below aims to facilitate your first appointment at Agoo and our team's understanding of your child's current and past strengths and difficulties. All information is strictly confidential and will be kept in your child's file for future reference. Any questions pertaining to the content of this questionnaire may be presented at your first meeting with Agoo. Please bring the completed questionnaire with you at your first meeting or return it to us by mail prior to your first scheduled appointment.

We thank you for also providing us with **copies of your child's most recent report card** as well as **copies of any previous therapy or assessment reports**.

A. Child's Identification

Child's Identification

First name: _____ Last name: _____

Date of birth: _____ Health Insurance Number: _____

Place of birth: _____ Date of arrival in Canada (if applicable): _____

Address: _____ (Civic number) _____ (Street name) _____ (Apt.) _____ (Town) _____ (Postal Code)

Mother tongue: English ☐ French ☐ Other: _____

Reason for consultation

What worries you in relation to your child's motor development?

_____

_____

_____

_____

_____

_____

_____

Parents' identification

Father's first name: _____ Father's last name : _____

Place of birth: _____ Date of arrival in Canada (if applicable): _____

Language(s) spoken:

- With your spouse: English ☐ French ☐ Other: _____
- With you child: English ☐ French ☐ Other: _____

Highest level of education completed: _____ Occupation: _____

Phone number: _____ Email: _____

Mother's first name: _____ Mother's last name: _____

Place of birth: _____ Age of arrival in Canada (if applicable): _____

Language(s) spoken:

- With your spouse: English ☐ French ☐ Other: _____
- With your child: English ☐ French ☐ Other: _____

Highest level of education completed: _____ Occupation : _____

Phone number: _____ Email: _____

B. Family History

Parents' marital status: Married ☐ Common-law ☐ Separated ☐ Divorced ☐

If parents are separated or divorced, the child lives:

With his mother ☐ With his father ☐ In shared custody ☐ In a reconstructed family ☐ Other ☐

Was the child adopted: Yes ☐ No ☐

Does the child live in a foster family or in foster care? Yes ☐ No ☐

Does the child have siblings? (names and age) _____

_____

Did any family member (mother, father, siblings, cousins, grandparents, uncles, aunts, etc.) suffers or suffered from the following difficulties:

Language delay ☐

Developmental Language Disorder (dysphasia) ☐

Motor deficits ☐

Learning disability (dyslexia, dysorthographia, dyscalculia, etc.) ☐

Autism Spectrum Disorder (ASD) ☐

Global developmental delay ☐

Mental delay ☐

Attention Deficit Hyperactivity Disorder (ADHD) ☐

C. Prenatal and postnatal history

Did the child's mother have any health issues during the pregnancy? Yes ☐ No ☐

If yes, please explain: _____

Were there complications during birth? Yes ☐ No ☐

If yes, please explain: _____

Was the pregnancy full term? Yes ☐ No ☐_____ weeks

Type of birth: Vaginal ☐ Caesarean section (c-section) ☐

What was the child's weight at birth? _____

Did the child suffer from any health complications following birth? Yes ☐ No ☐

If yes, please explain: _____

Were there early infancy feeding problems? Yes ☐ No ☐

If yes, please explain: _____

Were there early infancy sleep patterns difficulties? Yes ☐ No ☐

If yes, please explain: _____

Did your child experience any health problems during infancy? Yes ☐ No ☐

If yes, please explain: _____

As a baby, how did your child behave with other people?

More sociable than average ☐ Average sociability ☐ Less sociable than average ☐

D. Motor development

Please indicate at what age your child reached the following milestones:

Rolling over (back to front): _____

Rolling over (front to back): _____

Sitting unassisted: _____

Crawl on hands and knees: _____

Cruise (walk holding on to furniture): _____

Walk: _____

Are there any gross motor skills difficulties (ex. running, jumping, throwing, riding)? Yes ☐ No ☐

If yes, please explain: _____

Are there any fine motor skills difficulties (ex. buttoning, tying, drawing, cutting)? Yes ☐ No ☐

If yes, please explain: _____

Is your child: Right-handed ☐ Left-handed ☐ Undetermined ☐

E. School history

Daycare/School: _____ Year: _____

What type of daycare is/was your child attending?

☐ CPE ☐ Private daycare ☐ Family daycare

Daycare's/School's address: _____

Phone number: _____

Educator's/Teacher's name: _____

Did the educator/teacher mention any concern about your child? Yes ☐ No ☐

Please, explain: _____

F. Medical history

Family doctor / Pediatrician: _____

Address: _____

Phone number: _____

Is your child in overall good health? Yes ☐ No ☐

If no, please explain: _____

Has your child ever been hospitalized? Yes ☐ No ☐

If yes, when and why? _____

Does your child suffer from a chronic disease (ex. Asthma, diabetes)? _____

Does your child take a medication? Yes ☐ No ☐

If yes, what are the medication and the dosage? _____

Does your child have any allergies? Yes ☐ No ☐

If yes, please explain: _____

Has your child ever completed an eye exam? Yes ☐ No ☐

Were the results normal? Yes ☐ No ☐

If no, what was the problem?

Astigmatism ☐ Myopia ☐ Hypermetropia ☐ Strabismus ☐ Legally blind ☐ Other ☐

Has your child ever completed a hearing test? Yes ☐ No ☐ If yes:

At what age? _____ Where? _____

Were the results normal? Yes ☐ No ☐

If no, what was the problem? _____

Has your child ever had an ear infection? Yes ☐ No ☐

If yes, at what age and how many has he had since the first one? _____

Has your child had a myryngotomy and tubes? Yes ☐ No ☐

Has your child seen any other specialist or health professional in the past?

☐ Speech-Language Pathology _____ ☐ ENT _____

☐ Occupational therapy _____ ☐ Pedopsychiatry _____

☐ Audiology _____ ☐ Neurology _____

☐ Psychology_____ ☐ Other: _____

Do you or did you receive services from:

☐ CLSC ☐ CRDI ☐ Social worker

***** Please, bring a copy of all reports that you have! *****

What are your expectations in regards to physical therapy?

_____

_____

_____

_____

Please, add any information that was not previously mentioned that could be useful for the evaluation and/or therapy of your child. , or any information that could help us understand better your child's needs.

_____

_____

_____

_____

We thank you for taking the time to complete this questionnaire.

Person completing the questionnaire: _____ Relationship to the child: _____

Signature: _____ Date: _____