

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 <input type="checkbox"/>	French <input type="checkbox"/>	Other: _____
Language spoken at home:	English <input type="checkbox"/> _____%	French <input type="checkbox"/> _____%	Other: _____%
Language spoken at school:	English <input type="checkbox"/> _____%	French <input type="checkbox"/> _____%	Other: _____%

Reason for consultation

What worries you in relation to your child's language/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 <input type="checkbox"/> French <input type="checkbox"/> Other: _____
- With you child:	English <input type="checkbox"/> French <input type="checkbox"/> 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 <input type="checkbox"/> French <input type="checkbox"/> Other: _____
- With your child:	English <input type="checkbox"/> French <input type="checkbox"/> 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

Autism Spectrum Disorder (ASD)

Developmental Language Disorder (dysphasia)

Global developmental delay

Stuttering

Mental delay

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

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: Natural 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: _____

Potty training (day): _____

Potty training (night): _____

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. Language Development

Please answer the following questions about your child's first language.

- Babble? _____

At what age did your child: Say his first words (other than "mom" or "dad")? _____

- Combine two words together? _____

- Produce sentences? _____

Does your child like to repeat sounds, words or sentences? Yes No

Does your child follow simple directions (ex. Close the door)? Yes No

Does your child point at a common object (ex. Ball) on demand? Yes No

Does your child understand close-ended questions (yes/no)? Yes No

Does your child understand simple wh-questions (What? Who? Where?)? Yes No

Does your child have a difficulty with pronunciation? Yes No

If you answered yes to the previous question:

Do you understand what your child is saying? Yes No _____ %

Do strangers understand what your child is saying? Yes No _____ %

Is your child aware of his difficulties? Yes No

Please, explain: _____

How does your child express himself?

Gestures (ex. Pointing)

Sounds (grunting, cries)

Isolated words

2-word utterances

3-word sentences

4+-word sentences

Complete and complex sentences

F. Feeding

Do you have any feeding concerns (ex. difficulty to chew, difficulty to tolerate new textures)?

Yes No

Do you have concerns about hypersalivation? Yes No

G. Social history

Does your child experience any difficulty separating from you at times of departures (ex. Daycare)?

Yes No If yes, how did you child react? _____

Your child prefers to play with children:

Of his own age Younger Older He prefers to play by himself

What are your child's hobbies? _____

How much time does your child spends in front of a TV/phone screen on a typical day? _____

How does your child behave and interact with his siblings (skip this question if your child does not have siblings): _____

How does your child get along with his peers? _____

How does your child react when there is a conflict? _____

Please describe your child's personality/temperament: _____

H. School history

Daycare/School: _____ Year: _____

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: _____

At what age did your child start his current daycare? _____

If the current daycare is not your child's first daycare, at what age did you child start going to daycare? _____

If the current daycare is not your child's first daycare, what motivated you to switch? _____

How many days a week does/did your child go to daycare? _____

What is the language of instruction? _____

Please summarize your child's strengths and weaknesses for each academic level in regards to his academic skills, his emotional regulation, his behavior, his language and his social skills.

Daycare: _____

Kindergarten: _____

Cycle One (Grade 1 and 2): _____

Cycle Two (Grade 3 and 4): _____

Cycle Three (Grade 5 and 6): _____

Was your child held back in school? If yes, which grade? _____

Does your child benefit from academic accommodations? Yes No

Individualized Education Plan (IEP)

Special Education Technician

Assistive technologies (ex. Laptop)

Other: _____

Extra time to complete exams

Who helps your child with his homework? _____

How much time does it usually take your child to complete his homework? _____

I. 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 myringotomy 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! *****

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: _____