Agoo services familiaux et scolaires
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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: _____
Language spoken at home:	English ☐ ____ %	French ☐ ____ %	Other: ____ %
Language spoken at school:	English ☐ ____ %	French ☐ ____ %	Other: ____ %

Reason for consultation

What worries you in relation to your child's 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 ☐

Psychiatric and neurological conditions ☐

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, APGAR scores? _____

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. Sensory

Has difficulty performing tasks in a noisy environment?	Yes ☐ No ☐
Seems not to hear when spoken to (or seems to ignore adult)	Yes ☐ No ☐
Expresses anxiety during personal care (ex: struggles or cries when cutting his hair or nails, washing his face, getting dressed)?	Yes ☐ No ☐
Becomes anxious when he is near others?	Yes ☐ No ☐
Touches objects or people more than children of his age?	Yes ☐ No ☐
Searches for movement to the point where it interferes with his/her daily functioning?	Yes ☐ No ☐
Avoids sedentary activities?	Yes ☐ No ☐
Swings or rocks when sitting or waiting?	Yes ☐ No ☐
Moves in a rigid way, with stiffness?	Yes ☐ No ☐
Is easily tired?	Yes ☐ No ☐
Sticks him/herself to objects or walls?	Yes ☐ No ☐
Demonstrates a strong preference for certain tastes or smells?	Yes ☐ No ☐
Is selective about the tastes or textures of foods that he accepts in his diet?	Yes ☐ No ☐

F. Language Development

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

At what age did your child:

Babble? _____

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 understand close-ended questions (yes/no)? Yes ☐ No ☐

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

How does your child express himself?

☐ Gestures (ex. Pointing)
☐ 2-word utterances
☐ Complete and complex sentences

☐ Sounds (grunting, cries)
☐ 3-word sentences

☐ Isolated words
☐ 4+-word sentences

G. Sleep

Does your child fall asleep by himself? Yes ☐ No ☐

Is your child a light sleeper? Yes ☐ No ☐

Does your child sleep better without a blanket? Yes ☐ No ☐

Does your child sleep better with a heavy blanket? Yes ☐ No ☐

Does your child like to be rocked by his parents? Yes ☐ No ☐

At what time does your child usually go to bed? _____

Does your child nap during the day? Yes ☐ No ☐

If yes, when? _____

What is your child's sleep routine (ex. bath, reading)? _____

_____

How do you evaluate your child's sleep quality? _____

Is there anything else relevant to your child's sleeping habits? Yes ☐ No ☐

If yes, explain: _____

H. Feeding

Is/was your child breastfed? Yes ☐ No ☐

Does/did your child tolerate well purees with solid chunks? Yes ☐ No ☐

Does/did your child tolerate well solid foods? Yes ☐ No ☐

Does/did your child eat with his fingers? Yes ☐ No ☐

Does/did your child tolerate well the baby bottle when being held? Yes ☐ No ☐

Can your child use a spoon? Yes ☐ No ☐

Can your child use a fork? Yes ☐ No ☐

Can your child spread butter/jam/Nutella on a toast? Yes ☐ No ☐

Can your child drink from a sippy cup? Yes ☐ No ☐

Can your child drink from a cup? Yes ☐ No ☐

Can your child drink from a straw? Yes ☐ No ☐

Can your child pour himself some juice? Yes ☐ No ☐

Is your child selective about his foods? Yes ☐ No ☐

If yes, explain: _____

Does your child eat neatly? Yes ☐ No ☐

Does your child clean his mouth by himself? Yes ☐ No ☐

Does your child have difficulty chewing solid foods? Yes ☐ No ☐

Does your child tend to swallow without chewing? Yes ☐ No ☐

Does your child salivate a lot? Yes ☐ No ☐

Does/did your child follow a specific diet? Yes ☐ No ☐

If yes, explain: _____

Does your child have a good appetite? Yes ☐ No ☐

Does your child show specific behavior when he is eating? Yes ☐ No ☐

If yes, explain: _____

What foods does your child prefer? _____

What foods does he hate? _____

Is feeding a concern to you? Yes ☐ No ☐

I. Personal hygiene

Does your child usually take showers or baths? _____

Can your child wash his body or his hair by himself? Yes ☐ No ☐

If no, what kind of help does he need? _____

Can your child dry himself using a towel? Yes ☐ No ☐

Can your child brush his teeth by himself? Yes ☐ No ☐

Can your child brush his hair by himself? Yes ☐ No ☐

J. Toileting

Is your child toilet trained (daytime)? Yes ☐ No ☐

If yes, please indicate the age for :

Urine : _____ Bowel movement : _____

Is your child toilet trained (nighttime)? Yes ☐ No ☐

If yes, please indicate the age for:

Urine : _____ Bowel movement: _____

Can your child wipe himself? Yes ☐ No ☐

Does your child wake up during the night to go to the bathroom? Yes ☐ No ☐

K. Dressing

Can your child get dressed/undressed himself? Yes ☐ No ☐

If no, explain: _____

Does your child find it difficult to orient clothing? Yes ☐ No ☐

Does your child sometimes put his clothes backwards or inside out? Yes ☐ No ☐

Can your child button a shirt? Yes ☐ No ☐

Can your child use a zipper? Yes ☐ No ☐

Can your child tie his shoes? Yes ☐ No ☐

Can your child put on his shoes? Yes ☐ No ☐

Does your child put his shoes on the correct foot? Yes ☐ No ☐

L. Activities

Does your child have responsibilities in the house? Yes ☐ No ☐

If yes, explain: _____

Coloring

Does your child color inside the lines? Yes ☐ No ☐

Does your child color most of the paper? Yes ☐ No ☐

Does your child apply a lot of pressure on the crayon? Yes ☐ No ☐

Does your child always use the same color? Yes ☐ No ☐

Does your child color as well as another child of the same age? Yes ☐ No ☐

Does your child like to color? Yes ☐ No ☐

Crafting

Does your child have difficulty following all the steps and organising himself? Yes ☐ No ☐

Does your child craft as well as another child of the same age? Yes ☐ No ☐

Does your child like crafting? Yes ☐ No ☐

Writing

Does your child hold his pencil well? Yes ☐ No ☐

Is his work well organized on paper? Yes ☐ No ☐

Does your child write legibly? Yes ☐ No ☐

Does your child write fast enough to follow the rest of the class? Yes ☐ No ☐

Organizing

Does your child have trouble finding his things (ex. notebooks, pens)? Yes ☐ No ☐

M. Social history

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

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

Is your child outgoing? Yes ☐ No ☐

Does your child have best friends? Yes ☐ No ☐

Your child prefers to play with children:

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

Is your child often in conflicts with other children? Yes ☐ No ☐

Is your child often in conflict with adults in a position of authority? Yes ☐ No ☐

Does your child follow directions (i.e. does what he is told)? Yes ☐ No ☐

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? _____

What are your child's favorite activities? _____

Does your child participate in organized activities (ex. sports team, scout)? Yes ☐ No ☐

What are the activities your child dislikes the most?

What are the sedentary activities your child enjoys?

How much time does your child spend in front of a screen (computer, phone, and tablet) during a day?

Describe your child's best attributes and qualities:

How does your child respond to new situations?

What are the best types of corrective measures to use with your child?

How does your child respond to correction?

How is your child best comforted?

On the average, what percentage of the time does (s)he eventually comply with initial commands?

☐ 1-25%
☐ 50-75%
☐ 25-50%
☐ 75-100%

To what extent are you and your spouse consistent with respect to disciplinary strategies?

☐ 1-25%
☐ 50-75%
☐ 25-50%
☐ 75-100%

What is the percentage of parenting involvement?

Father:
Mother:

Extended family:

What time of the day is most difficult for your child?

☐ morning
☐ afternoon
☐ evening
☐ night time

Describe and state the time of day that your child is most responsive, productive and happy?

☐ morning ☐ afternoon

☐ evening ☐night time

Have any of the following stressful events occurred within the past 12 months:

☐ Parents divorced or separated ☐ Accident or illness in the family ☐Moved ☐ Trauma

☐Death in the family ☐ Changed school/ daycare ☐Financial problems ☐

What activities do you do as a family:

Describe a typical weekend:

Describe a typical weekday:

Select the social emotional learning skills (emotional intelligence) you think your child needs to work on?

Self-awareness: To recognize one's emotions and thoughts and their influence on behavior. Yes ☐ No ☐

Decision making skills: To make constructive and respectful choices about personal behavior and social interactions. Yes ☐ No ☐

Self-management: To regulate one's emotions, thoughts, and behaviors effectively in different situations. Yes ☐ No ☐

Social awareness: To understand social and ethical norms for behaviour. Yes ☐ No ☐

Relationship skills: to establish and maintain healthy and rewarding relationships with diverse individuals and groups. Yes ☐ No ☐

A. 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: _____

If your child is a preschooler:

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 your 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 time is your child brought to school and picked up from school? AM: PM: _____

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? _____

B. 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 (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

What is your main concern (*place examples in appropriate section)?*

Home? Yes ☐ No ☐

School? Yes ☐ No ☐

Other? Social gatherings, organized or non organized activities Yes ☐ No ☐

How long have you had this concern? ☐ - 3 months ☐ 3 to 6 months ☐ 6 to 12 months ☐1 to 2yrs+

What are your expectations in regards to neuropsychology, psychology, occupational therapy, psychoeducation or psychopedagogy?

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

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

Signature: _____ Date: _____