Agoo Family and School Services
3230 Boulevard Curé-Labelle #305, Laval,
QC H7P 0H9
450-687-6888 Ext. 113

***** CONFIDENTIAL *****

DEVELOPMENTAL HISTORY QUESTIONNAIRE

Children & Adolescents

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. Additional questionnaires may be provided to you for completion at your first appointment. 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.

CHILD IDENTIFICATION		
Name:	**Last Name:**	
Age:	**Birth Date:**	**Gender:**
Place of Birth:	**Date of Arrival in Canada (if applicable):**	
Mother tongue: English ☐ French ☐ Other: _____		
Language spoken at home: English ☐ French ☐ Other: _____		
Language spoken at school: English ☐ French ☐ Other: _____		
Current Address:		

FAMILY INFORMATION	
Mother's Full Name:	**Age:**
Place of Birth:	**Date of Arrival in Canada (if applicable):**
Language(s) spoken:	
Highest Level of Education Completed:	**Occupation:**
Current Address (if different than child's):	
Telephone: Home: ( )	**Other: ( )**

Father's Full Name:	**Age:**
Place of Birth:	**Date of Arrival in Canada (if applicable):**
Language(s) spoken:	
Highest Level of Education Completed:	**Occupation:**
Current Address (if different than child's):	
Telephone: Home: ( )	**Other: ( )**
Parents' Marital Status: Married ☐ Common Law ☐ Separated ☐ Divorced ☐	

SIBLINGS		
Name:	**Last Name:**	
Age:	**Gender:**	**Place of Birth:**
Highest Level of Education Completed:		**Occupation:**
Academic difficulties: Yes ☐ No ☐ Please explain:		
Behavioural difficulties: Yes ☐ No ☐ Please explain:		
Health/Medical difficulties: Yes ☐ No ☐ Please explain:		
Mental Health difficulties: Yes ☐ No ☐ Please explain:		

Name:	**Last Name:**	
Age:	**Gender:**	**Place of Birth:**
Highest Level of Education Completed:		**Occupation:**
Academic difficulties: Yes ☐ No ☐ Please explain:		
Behavioural difficulties: Yes ☐ No ☐ Please explain:		
Health/Medical difficulties: Yes ☐ No ☐ Please explain:		
Mental Health difficulties: Yes ☐ No ☐ Please explain:		

Name:	**Last Name:**	
Age:	**Gender:**	**Place of Birth:**
Highest Level of Education Completed:		**Occupation:**
Academic difficulties: Yes ☐ No ☐ Please explain:		
Behavioural difficulties: Yes ☐ No ☐ Please explain:		
Health/Medical difficulties: Yes ☐ No ☐ Please explain:		
Mental Health difficulties: Yes ☐ No ☐ Please explain:		

Name:	**Last Name:**	
Age:	**Gender:**	**Place of Birth:**
Highest Level of Education Completed:		**Occupation:**
Academic difficulties: Yes ☐ No ☐ Please explain:		
Behavioural difficulties: Yes ☐ No ☐ Please explain:		
Health/Medical difficulties: Yes ☐ No ☐ Please explain:		
Mental Health difficulties: Yes ☐ No ☐ Please explain:		

FAMILY HISTORY

If parents are separated or divorced, the child lives:

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

Is the child adopted? Yes ☐ No ☐

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

Please describe the family situation (Who lives with the child? Parents' separation? Details of shared custody? Step-siblings? Etc.)

_____

_____

_____

_____

_____

Does the child share any religious values? Yes ☐ No ☐

If so, which religion does the child practice? _____

If your child was born or lived part of his life abroad, please describe his life prior to his arrival in Canada (How long did he live abroad? What were the living conditions like? How did he/she spend his time? Etc.)

_____

_____

Does your family share any important cultural values or beliefs that may help us better understand your child's reality?

_____

_____

Please indicate whether any family members (parents, siblings, aunts/uncles, cousins, grand-parents) suffer or have suffered from the following difficulties:

		Which family member suffered from this?	Was treatment received?	If so, what kind of treatment?
Inattention	Yes ☐ No ☐		Yes ☐ No ☐	
Hyperactivity	Yes ☐ No ☐		Yes ☐ No ☐	
Learning difficulty	Yes ☐ No ☐		Yes ☐ No ☐	
Intellectual disability	Yes ☐ No ☐		Yes ☐ No ☐	
Autism Spectrum Disorder	Yes ☐ No ☐		Yes ☐ No ☐	
Depression	Yes ☐ No ☐		Yes ☐ No ☐	
Anxiety	Yes ☐ No ☐		Yes ☐ No ☐	
Behavioural issues	Yes ☐ No ☐		Yes ☐ No ☐	
Feeding difficulty	Yes ☐ No ☐		Yes ☐ No ☐	
Sleep problems	Yes ☐ No ☐		Yes ☐ No ☐	
Chronic Pain	Yes ☐ No ☐		Yes ☐ No ☐	
Epilepsy	Yes ☐ No ☐		Yes ☐ No ☐	
Diabetes	Yes ☐ No ☐		Yes ☐ No ☐	
Obesity	Yes ☐ No ☐		Yes ☐ No ☐	
High Blood Pressure	Yes ☐ No ☐		Yes ☐ No ☐	
Alcoholism	Yes ☐ No ☐		Yes ☐ No ☐	
Drug abuse	Yes ☐ No ☐		Yes ☐ No ☐	
Problems with the law	Yes ☐ No ☐		Yes ☐ No ☐	
Early death (before the age of 40)	Yes ☐ No ☐		Yes ☐ No ☐	
Other:	Yes ☐ No ☐		Yes ☐ No ☐	

PRENATAL HISTORY

How was your (or the child's mother's) health during pregnancy?

☐ Good ☐ Fair ☐ Poor ☐ Don't Know

Did you (or his/her mother) have any illness or complications during pregnancy with this child?

☐ Yes ☐ No

Please explain: _____

_____

How old were you (or your child's mother) when (s)he was born? _____

Was the pregnancy: Planned ☐ or Unplanned ☐

Wanted ☐ or Unwanted ☐

Do you recall any of the following substances or medications being used during pregnancy?

		How many times?
Beer or wine	Yes ☐ No ☐	
Hard liquor	Yes ☐ No ☐	
Coffee or other caffeine (Coke, etc.)	Yes ☐ No ☐	
Cigarettes	Yes ☐ No ☐	
Drugs (Marijuana, cocaine, etc.)	Yes ☐ No ☐	
Valium (Librium, Xanax)	Yes ☐ No ☐	
Tranquilizers	Yes ☐ No ☐	
Anti-seizure medications (Dilantin)	Yes ☐ No ☐	
Antibiotics (for viral infections)	Yes ☐ No ☐	
Sleeping pills	Yes ☐ No ☐	
Other:	Yes ☐ No ☐	

Was there anything unusual about the delivery or birth? ☐ Yes ☐ No
Please explain: _____

Were there any signs of fetal distress during labor or birth? ☐ Yes ☐ No ☐ Don't Know

Your child was born at how many weeks of gestation? _____

Was the delivery: Natural? ☐ Yes ☐ No

Breech? ☐ Yes ☐ No

Caesarian? ☐ Yes ☐ No

Forceps? ☐ Yes ☐ No

Induced? ☐ Yes ☐ No

What was your child's birth weight? _____

Were there any health complications following birth? ☐ Yes ☐ No
Please explain: _____

POSTNATAL PERIOD AND INFANCY

Were there early infancy feeding problems?

☐ Yes ☐ No
Please explain: _____

Was your child colicky? ☐ Yes ☐ No

Were there early infancy sleep pattern difficulties? ☐ Yes ☐ No
Please explain: _____

Were there problems with your infant's alertness? ☐ Yes ☐ No
Please explain: _____

Did your child experience any health problems during infancy? ☐ Yes ☐ No
Please explain: _____

Did your child have any congenital problems? ☐ Yes ☐ No
Please explain: _____

Were the first months at home following birth difficult (e.g., Was your child an easy baby? Did (s)he follow a schedule fairly well)? ☐ Yes ☐ No

Please explain: _____

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

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

When (s)he wanted something, how insistent was (s)he?

☐ Very insistent ☐ Pretty insistent ☐ Average ☐ Not very insistent ☐ Not at all insistent

How would you rate the activity level of your child as an infant/toddler?

☐ Very active ☐ Active ☐ Average ☐ Less active ☐ Not active

DEVELOPMENTAL MILESTONES

Please indicate at what age your child achieved the following skills (Please indicate the number of months, if possible).

Sit up on his/her own:	
Crawl (walk on all four):	
Walk without assistance:	
Speak single words (other than mama or dada):	
String/Combine two or more words:	
Use complete sentences to describe events/activities:	
Potty training (bladder control):	
Potty training (bowel control):	
Night time potty training:	

Approximately how much time did toilet training take from onset to completion? _____

Compared to other children the same age, did your child experience difficulty with:

Gross motor abilities (e.g., running, jumping, throwing a ball, riding a bike)	☐ Yes ☐ No
Fine Motor abilities (e.g., buttoning, tying, drawing, cutting)	☐ Yes ☐ No
Pre-academic skills (e.g., learning colours, the alphabet, shapes)	☐ Yes ☐ No
Staying seated to listen to a story or watch a movie	☐ Yes ☐ No
Playing or socializing with other children	☐ Yes ☐ No

Does your child understand limits? ☐ Yes ☐ No

Does your child understand danger? ☐ Yes ☐ No

Are there any self-care, feeding, dressing or grooming concerns? ☐ Yes ☐ No
If yes, please explain: _____

SOCIAL HISTORY

Did your child experience any difficulty separating from you at times of departures (e.g., at daycare)?

☐ Yes ☐ No If so, until what age? _____

Does your child prefer playing with children who are:

☐ His/her age ☐ Younger than him/her ☐ Older than him/her

How many hours a week does your child spend interacting with other children? _____

How does (s)he get along with his/her brothers/sisters?

☐ Doesn't have any ☐ Better than average ☐ Average ☐ Worse than average

How does (s)he get along with peers?

☐ Easier than average ☐ Average ☐ Worse than average ☐ Don't Know

On average, how long does (s)he maintain friendships?

☐ Less than 6 months ☐ 6 months - 1 year ☐ More than 1 year ☐ Don't Know

Please indicate whether your child or family has been through any particular, traumatizing or stressful events, noting when these events occurred.

☐ Move: _____ ☐ Physical/Sexual abuse: _____

☐ Birth of a sibling: _____ ☐ Parents' divorce/separation: _____

☐ Change of school: _____ ☐ Family recomposition: _____

☐ Death of a parent: _____ ☐ Other death: _____

☐ Job loss: _____ ☐ Violence/War: _____

☐ Start of school: _____ ☐ Bullying: _____

☐ Poverty: _____ ☐ Other: _____

☐ Illness: _____ _____

SCHOOL HISTORY

SCHOOL: _____ GRADE: _____

SCHOOL'S ADDRESS: _____

_____

SCHOOL'S TELEPHONE: (_____)_____

TEACHER'S NAME: _____

SCHOOL COUNSELOR: _____

When did your child begin attending class at his current school? _____
How many schools did (s)he attend prior to this? _____

Please summarize the general school progress (e.g., academic, social, testing) within each of these grade levels. Please describe strengths as well as problem areas or weaknesses in cognitive/academic skills and behavioral control.

Preschool

_____

_____

Kindergarten

_____

_____

Grades 1 through 3

_____

_____

Grades 4 through 6

_____

_____

Grades 7 through 12

_____

_____

Has your child ever been in any type of special educational program, and, if so, for how long?

☐ Learning disabilities class Duration: _____

☐ Behavioral/emotional disorders class Duration: _____

☐ Speech and language therapy Duration: _____

☐Other (please specify): _____

Has your child ever received any academic accommodations, and, if so, please explain?

☐ Modified time allowances: _____

☐ Assistive technologies: _____

☐ Teacher's Aid: _____

☐ Individualized Education Plan: _____

☐ Other (please specify): _____

Has (s)he ever been (Please describe reasons and give brief details):

☐ Suspended from school: _____ Number of Suspensions: _____

☐ Expelled from school: _____ Number of expulsions: _____

☐ Retained in grade: _____ Number of retentions: _____

☐ Skipped or accelerated a grade: _____ Number of accelerations: _____

Have any other instructional modifications been attempted? ☐ Yes ☐ No
If yes, please specify: _____

Do you have any concerns about your child's progress in any of the following academic areas?

☐ Reading ☐ Writing ☐ Mathematics ☐ Other: _____

Does she/he have any communication or auditory processing problems? ☐ Yes ☐ No
If yes, please explain: _____

Does she/he have any visual processing or dyslexia-type problems? ☐ Yes ☐ No
If yes, please explain: _____

Does she/he have difficulty with problem solving or comprehension? ☐ Yes ☐ No
If yes, please explain: _____

Upon returning home from school, your child is:

☐ Tired ☐ Agitated ☐ Complaining of a headache ☐ Other: _____

Who helps your child to complete his homework? _____

How much time does your child spend completing homework at night? _____

Is completing homework difficult for your child? ☐ Yes ☐ No
If yes, please explain: _____

MEDICAL HISTORY:

FAMILY DOCTOR/PEDIATRICIAN: _____

ADDRESS: _____

_____

TELEPHONE NUMBER: (____)_____

How would you describe your child's health?

☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

When was your child's last medical exam? _____

What were the results of your child's last check-up?

☐ Normal ☐ Health difficulty: _____ ☐ New medical diagnosis: _____

Current medication(s) and dosage:

_____

_____

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

Were the results normal? ☐ Yes ☐ No
If not, what was the issue:

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

Has your child ever completed a hearing exam? ☐ Yes ☐ No When? _____

Were the results normal? ☐ Yes ☐ No
If not, what was the issue: _____

Does your child suffer from a chronic health problem (e.g., asthma, diabetes, heart condition)?

☐ Yes ☐ No
If yes, please specify: _____

When was the onset of any chronic illness? _____

Which of the following illnesses has your child had?

☐ Mumps ☐ Pneumonia

☐ Chicken Pox ☐ Encephalitis

☐ Measles ☐ Otitis Media

☐ Whooping Cough ☐ Lead Poisoning

☐ Scarlet Fever ☐ Seizures

☐ Other: _____

Has your child had any accidents resulting in the following? Please give date (year) and cause of injury.

☐ Broken bones: _____

☐ Severe lacerations: _____

☐ Head injury: _____

☐ Stomach pumped: _____

☐ Eye injury: _____

☐ Sutures: _____

☐ Other: _____

Has your child ever been hospitalized or received a surgical procedure? ☐ Yes ☐ No
If so, when: _____ Hospital: _____

Duration of hospitalization: _____ Reason: _____

Has your child ever been hospitalized or received a surgical procedure for a second time? ☐ Yes ☐ No
If so, when: _____ Hospital: _____

Duration of hospitalization: _____ Reason: _____

Has your child ever been hospitalized or received a surgical procedure for a third time? ☐ Yes ☐ No
If so, when: _____ Hospital: _____

Duration of hospitalization: _____ Reason: _____

Do you suspect your child is consuming alcohol or illegal substances (including marijuana)? ☐Yes ☐No
How often does your child consume caffeinated substances (including soft drinks, chocolate)? _____

How would you describe your child's appetite?

☐ Overeats ☐ Average ☐ Under eats

Does your child suffer from any sleeping difficulty? ☐ Yes ☐ No
How would you describe your child's sleep?

☐ Restless ☐ Deep ☐ Difficulty falling asleep ☐ Talks in his sleep ☐ Snores ☐ Sleepwalks

☐ Fears the dark ☐ Wakes up often ☐ Has nightmares/night terrors ☐ Other

Does your child have bladder control problems at night? ☐ Yes ☐ No

If yes, how often does (s)he wet the bed? _____ If yes, was (s)he ever continent? ☐ Yes ☐ No

On average, on weekdays, your child wakes up at ____:____ and goes to bed at ____:____.
On weekends, (s)he wakes up at ____:____ and goes to bed at ____:____.
How long does your child take to fall asleep? _____

When (s)he wakes up in the morning, does (s)he usually look rested? ☐ Yes ☐ No

Does your child share a room with someone else? ☐ Yes ☐ No If so, who? _____

Does (s)he sometimes sleep with you? ☐ Yes ☐ No If so, how often? _____

Is your child currently receiving or previously received the following services:

Psychiatry: ☐ Yes ☐ No
Name of Psychiatrist: _____ Site: _____
Duration of treatment (start and end dates): _____
Reason and results: _____

Psychology: ☐ Yes ☐ No
Name of Psychologist: _____ Site: _____
Duration of treatment (start and end dates): _____
Reason and results: _____

Speech-Language Pathology: ☐ Yes ☐ No
Name of therapist: _____ Site: _____
Duration of treatment (start and end dates): _____
Reason and results: _____

Occupational Therapy: ☐ Yes ☐ No
Name of Therapist: _____ Site: _____
Duration of treatment (start and end dates): _____
Reason and results: _____

Social Work: ☐ Yes ☐ No
Name of Social Worker: _____ Site: _____
Duration of treatment (start and end dates): _____
Reason and results: _____

Individual psychotherapy: ☐ Yes ☐ No Duration of therapy_____
Group psychotherapy: ☐ Yes ☐ No Duration of therapy_____
Family therapy with child: ☐ Yes ☐ No Duration of therapy_____
Inpatient evaluation: ☐ Yes ☐ No Type of evaluation: _____
Residential treatment: ☐ Yes ☐ No Duration of placement_____

NATURE OF CURRENT DIFFICULTIES

Please identify the nature of your child's current difficulties within the list below. Note that difficulties might be present in more than one area.

- ☐ Motor Development (Fine and gross motor abilities)
- ☐ Social Skills (e.g., understanding and expressing emotions, making friends, bullying)
- ☐ Academics (e.g., reading, writing, mathematics)
- ☐ Attention/Concentration
- ☐ Language development (e.g., vocabulary, comprehension, pronunciation)
- ☐ Behaviour/Compliance (e.g., defiance, aggression, hyperactivity)
- ☐ Mood and Affect (anxiety, depression, low self-esteem)
- ☐ Health (e.g., fear of needles, pill swallowing, constipation, treatment compliance)
- ☐ Other: _____

Please describe your child's current difficulties as identified above. Be as detailed as possible (Presentation of the difficulties? When have the difficulties started? What is the severity of the difficulties? Which areas of your child's life do the difficulties affect? Etc.).

_____

_____

_____

_____

_____

_____

Is your child currently receiving of has he previously received assistance/treatment for the difficulties described above?

_____

_____

_____

What kind of services are you hoping to receive for your child's current difficulties?

☐ Psychoeducation (I want to understand my child's difficulties)

☐ Assessment (I want my child's difficulties to be evaluated in order to receive specific recommendations about how I and others can help my child)

☐ Therapy (I want to treat my child's difficulties)

What are your desired outcome for psychoeducation, therapy or assessment? What changes do you want to see?

_____

_____

_____

What strategies have been implemented to address these problems or achieve these goals?

	Tried?	Did it work?
Verbal reprimands	☐ Yes ☐ No	☐ Yes ☐ No
Time out (isolation)	☐ Yes ☐ No	☐ Yes ☐ No
Removal of privileges	☐ Yes ☐ No	☐ Yes ☐ No
Rewards	☐ Yes ☐ No	☐ Yes ☐ No
Physical punishment	☐ Yes ☐ No	☐ Yes ☐ No
Acquiescence to child	☐ Yes ☐ No	☐ Yes ☐ No
Avoidance of child	☐ Yes ☐ No	☐ Yes ☐ No
Screaming/Yelling	☐ Yes ☐ No	☐ Yes ☐ No
Explaining/Talking	☐ Yes ☐ No	☐ Yes ☐ No
Other:	☐ Yes ☐ No	☐ Yes ☐ No

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

☐ Most of the time ☐ Some of the time ☐ None of the time

Do you and your spouse share similar parenting approaches? ☐ Yes ☐ No

Please explain: _____

_____

_____

Please provide any information not addressed above that would help with assessment/treatment and/or help in understanding your child's current needs.

_____

_____

_____

_____

_____

_____

_____

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

Person completing this questionnaire: _____ Relationship to child: _____

Signature: _____ Date:_____