

Developmental History

NEUROPSYCHOLOGY/ PSYCHOLOGY/ERGOTHERAPY/PSYCHOÉDUCATION

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

Motor deficits

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

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: 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: _____

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 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)

Sounds (grunting, cries)

Isolated words

2-word utterances

3-word sentences

4+-word sentences

Complete and complex sentences

F. 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: _____

G. 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

H. 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

I. 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

J. 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 you 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

K. 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 lisibly? 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

L. 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? _____

- 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. do 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? _____

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

Please describe your child's personality/temperament: _____

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? _____

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 dislike the most? Yes No

M. 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 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? _____

N. 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! *****

What are your expectations in regards to occupational 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: _____