PARENT QUESTIONNAIRE

Today's Date:_____

Name of Person Completing this Form: _____

Student's Name: _____ Date of Birth: _____

Home Address: _____

Home Number: _____ Cell Number: _____

Email address:_____

School: _____ Grade: _____

Please list the current concerns you are having about your child?

1._____

2._____

3._____

4._____

5._____

6._____

What previous treatments or supports that have been attempted? Dates? Effectiveness? (e.g., counseling, tutoring, diets, speech/language, OT, therapy)

1._____

2._____

3._____

4._____

Were you specifically referred by someone? If so, by whom?

Has your child ever had any previous educational and/or psychological evaluations?

_____
_____
_____

Please indicate your child's strengths/unique talents and interests:

1._____

2._____

3._____

4._____

5._____

Please list all previous schools that your child has attended:

1._____

2._____

3._____

4._____

Please list current medication(s), dosages, name of prescribing physician/ psychiatrist and when first prescribed:

_____

What would you hope to get out of this evaluation for your child?

1._____

2._____

3._____

EARLY HISTORY:

Any problems/complications during pregnancy?

_____
_____
_____
_____

Any medications and/or medical treatments during pregnancy?

_____
_____
_____

Any problems during labor/birth?

_____
_____
_____

Length of Pregnancy?

_____ months

Birth Weight? ___ lbs. ____ ozs.

Apgar Scores: _____

Any newborn problems (e.g., jaundice, difficulty breathing, cord around neck, trouble sucking, jittery, needed oxygen)? Was he/she a twin?

_____
_____
_____
_____

Was he/she required to stay in the hospital more than the normal 2-3 days?

___ No ____ Yes If Yes, please explain:

_____
_____

Please list all heath conditions (present and past) – please provide dates:

1._____

2._____

3._____

4._____

5._____

6._____

Has this student ever been hospitalized? ____ Yes ____No

If so, when/what condition?

_____
_____

Has your child ever had any of the following conditions? If so, please explain and provide dates:

Head Injuries/Concussions	____ Yes	____ No
Traumas	____ Yes	____ No
Serious illnesses	____ Yes	____ No
Allergies	____ Yes	____ No
Accidents/Injuries	___ Yes	____ No

If yes to any above, please explain and provide dates:

_____
_____
_____

Date of last physical examination? _____

Any vision problems? ____ Yes ____ No

Any hearing Problems: ____ Yes ____No

Date/results of last vision and hearing tests: _____

Please list all <u>previous</u> medication(s) used over a long period of time

_____
_____
_____

Please list all other significant illnesses?

_____

_____

Please describe your child as a toddler? Any concerns?

_____
_____
_____

EARLY DEVELOPMENT (Please indicated the approximate time period - age)

Sat up without help _____ Walked alone _____

Crawled_____ Walked up stairs_____

Spoke first words (mama, dada, etc.) _____

Spoke 2-3 word sentences _____

Used fingers to feed self _____

Fully bowel trained _____

Fully bladder trained _____

Able to dress self_____ Able to tie shoelaces_____

Any developmental or other concerns during your child's 1st year of life?

_____
_____

Did this student attend preschool? If so, any concerns?

_____

_____

_____

Was this student ever retained in a grade?

____ Yes ____ No

If so, when? Why?

Has this child endured any extremely stressful experiences?

_____

_____

_____

FAMILY HISTORY

Father's Age: _____ School Level Completed: _____

Occupation: _____ General Health: _____

Mother's Age: _____ School Level Completed:_____

Occupation:_____ General Health: _____

Brother(s) Age: _____

Sister(s) Age: _____

What is the principal language spoken at home?_____

Indicate others languages that are sometimes used?_____

Please check any that apply:

__ Was adopted ___ Is a foster child

Parents are: ___ Together ___ Separated ___ Divorced

Has anyone in the family ever had any previous diagnoses or treatment as a child or adult for learning disabilities, attention deficit disorder, anxiety, depression, mental retardation, behavioral problems. (Pleases include parents, siblings, grandparents, cousins, etc).

_____
_____
_____
_____
_____

Any family problems? If so, please describe:

_____
_____
_____

Please describe your child's relationships with members of his immediate family (parents, siblings). Any concerns?

_____
_____
_____
_____

EDUCATIONAL HISTORY:

Describe any learning problems your child may have had in the past/present:

In elementary school?

_____
_____
_____
_____

In middle school?

_____
_____
_____
_____

In high school?

_____
_____
_____
_____

Has your child ever experienced any <u>significant difficulties over a period of more than 6 months</u> in the following areas? If so, when? Check if yes.

____Attention; ____Organization; ____Forgetfulness; ____Being Bullied

____Homework Completion; ___Making/keeping friends; ___Test taking

____Anxiety; ___Depression; ____Hyperactivity; ____Distractibility

____Aggression; ___Behavior/Compliance; ____School Refusal; ___Confidence

Describe any social/emotional problems your child may have had in the past/present:

In elementary school?

_____
_____
_____
_____

In middle school?

_____
_____
_____
_____

In high school?

_____
_____
_____
_____

Has your child had any previous or current suicidal or self-injurious behavior or verbalizations? ___ Yes ___ No

Has your child/adolescent ever experimented with drugs, cigarettes or alcohol?

___ Yes ___ No - If yes, please describe.

_____

Did your child have any problems learning to read?

____ Yes ____ No - If yes, please explain.

Did your child have any problems learning to write? Spell?

___ Yes ___ No – If yes, please explain.

Did your child have any problems learning math?

___Yes ___ No – If yes, please explain.

Has your child received any special educational services? Did he/she ever have an IEP, Section 504 plan, accommodations (formal or informal), or specialized tutoring?

If so, please describe:

_____

_____

_____

List three or more positive attributes about your child?

_____

_____

Thank you for taking the time to complete this Questionnaire

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