



Parent Questionnaire



Thank you for taking the time to answer the following questions. The information you provide about your child is essential. Together with referral information from other professionals and the clinical information gathered by the practitioner, the history, background and personal data provided by parents forms a vital and integral part of the total picture.

This questionnaire along with the Teacher Questionnaire (filled out by the Classroom Teacher) should be handed to our administration staff on arrival.

Please fill out the following and then answer the questions on the remaining pages.

Child's SURNAME: _____ Child's FIRST NAME: _____

Date of Birth: _____ Sex: (please circle) Male Female

Current School: _____

Thank You For Your Cooperation

Parents Concerns, Opinions and Comments

What does your child do well, what do they enjoy, and what do you like about them?

Overall, how concerned (worried) are you about your child?

	<i>Not at all</i>	<i>A little</i>	<i>Moderately</i>	<i>Quite a lot</i>	<i>Extremely</i>
Mother	1 _____	2 _____	3 _____	4 _____	5 _____
Father	1 _____	2 _____	3 _____	4 _____	5 _____

What questions would you like answered about your child?

What would you like help with in managing (& what would you like to achieve)?

Medical Issues for Your Child

If you have been referred to Literacy Care by a Paediatrician (not a GP) and you have a referral letter from that Doctor then skip these questions

Any concerns about your child's health currently ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any concerns about the pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any concerns about the birth and postnatal period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any accidents / injuries / serious illnesses in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fully immunised?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Are you worried about:

High Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diet and Eating Habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sleep Patterns	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Attention and Concentration	<input type="checkbox"/> Yes	<input type="checkbox"/> No

What was the birth weight? _____ If premature, how many weeks? _____

As your child was growing up, were you concerned about any of the following?

The first year? (e.g. hard to settle, poor weight gain?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Early motor development (sitting, walking, running, kicking)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Early language (talking and understanding)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Early social development (eye contact, play, friends)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Early learning (e.g. colours, shapes, drawing)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Diagnosed Conditions

Has the child been formally (by a medical practitioner) diagnosed with any of the following? **(Please Tick ✓)**

Attention Deficit Disorder	<input type="checkbox"/>	Psychotic Disorders	<input type="checkbox"/>
Attention Deficit Hyperactivity Disorder	<input type="checkbox"/>	Non Verbal Learning Disability	<input type="checkbox"/>
Oppositional Defiant Disorder	<input type="checkbox"/>	Anxiety Disorders	<input type="checkbox"/>
Autism	<input type="checkbox"/>	Aspergers Syndrome	<input type="checkbox"/>
Dyslexia	<input type="checkbox"/>	Dyspraxia	<input type="checkbox"/>

Other (Please Describe) _____

Is the child on any medication relative to learning or behaviour? **(Please Tick ✓)** Yes No

If Yes please give details: _____

Are there any specific psychological, medical, developmental or family issues you would like to discuss?

Has *hearing* been checked? Yes No If yes, is it normal Yes No
 Has *vision* been checked? Yes No If yes, is it normal? Yes No

Family and Hereditary Factors

Does anybody in the family (siblings, parents, grandparents, aunts, etc have problems similar to, or the same as your child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, please briefly explain: _____

Does anybody in the family (siblings, parents, grandparents, aunts, uncles etc) have different problems, of a developmental, learning, behavioural, emotional or psychiatric nature?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, please briefly explain: _____

Previous Professional Involvement and Management

Who have you consulted for your child's difficulties? (Remember to bring a copy of all written reports!)

	Currently [✓]	In the Past [✓]	<i>Who?</i>
Health Services			
Paediatrician			
Child Psychiatrist			
Occupational Therapist			
Physiotherapist			
Speech Pathologist			
Psychologist			
Social Worker / Counselor			
Education Services			
School Guidance Officer			
Support / Remedial Teacher			
Home Tutor			
Other (e.g. Naturopath)			

For any professionals identified, please summarise the involvement. (When it started / ceased, how often, what was undertaken)

Academic and Scholastic Interventions

Has the child participated or is the child currently participating in any of the following: **(Please ✓)**

- | | | |
|--------------------------------------|--------------------------|--|
| 1. Reader Recovery | <input type="checkbox"/> | Current / Concluded (Please Circle) |
| 2. Supporter Reader | <input type="checkbox"/> | Current / Concluded |
| 3. One to one or small group tuition | <input type="checkbox"/> | Current / Concluded |
| 4. Another literacy program | <input type="checkbox"/> | Current / Concluded |
| 5. A Math program | <input type="checkbox"/> | Current / Concluded |
| 6. Private Tuition | <input type="checkbox"/> | Current / Concluded |
| 6. Other: (Please specify) | <input type="checkbox"/> | Current / Concluded |

Educational Information

Please circle the level that best describes your child's general academic and scholastic progress:

Well Below Average Below Average Average Above Average Well Above Average

Which is your child's best subject?

Can your Child Do the Following: (Please Tick ✓)

- | | |
|--------------------------------------|--------------------------|
| Recite the Alphabet | <input type="checkbox"/> |
| Name the months of the year in order | <input type="checkbox"/> |
| Name the days of the week in order | <input type="checkbox"/> |
| Count up in 2's | <input type="checkbox"/> |
| Count Backwards from 15-0 | <input type="checkbox"/> |

About Literacy

(Fill out the Following Relative to the Child's Reading, Spelling and Writing)

Behaviour (Please ✓)

- | | |
|--|--------------------------|
| 1. Holds book very close | <input type="checkbox"/> |
| 2. Avoids close work | <input type="checkbox"/> |
| 3. Loses place, skips lines | <input type="checkbox"/> |
| 4. Omits words or makes errors when copying | <input type="checkbox"/> |
| 5. Confuses similar words, fails to recognize same word in different context | <input type="checkbox"/> |
| 6. Has short attention span | <input type="checkbox"/> |
| 7. Has a poor or unusual sitting posture | <input type="checkbox"/> |
| 8. Tilts head excessively to one side, up or down | <input type="checkbox"/> |
| 9. Makes excessive head movements | <input type="checkbox"/> |
| 10. Squints or frowns to see the blackboard clearly | <input type="checkbox"/> |
| 11. Rubs eyes frequently | <input type="checkbox"/> |
| 12. Makes errors in coping at near or from distance to near | <input type="checkbox"/> |
| 13. Omits suffixes such as 's', 'ed', 'ing'. | <input type="checkbox"/> |

Complaints (Please ✓)

- | | |
|--|--------------------------|
| 1. Headaches | <input type="checkbox"/> |
| 2. Blurring of vision | <input type="checkbox"/> |
| 3. Seeing double | <input type="checkbox"/> |
| 4. Eye burning or itching during or after close work | <input type="checkbox"/> |

- 5. Words moving on the page
- 6. Colours appearing on the page
- 7. Hard to read under florescent light

Errors (Please ✓)

- 1. Reads whole words backwards e.g. 'on' for 'no', 'saw' for 'was'
- 2. Trouble learning left and right
- 3. Reverses letters and numbers
- 4. Poor recall of visually presented material
- 5. Can respond orally but not in writing
- 6. Untidy handwriting
- 7. Trouble spelling irregular words (words that can't be sounded out)
- 8. Erases excessively
- 9. Poor reading yet comprehension good when listening
- 10. Puts letters in wrong order, reading 'felt' as 'left', 'act' as 'cat'.
- 11. Cannot match same letter when asked to
- 12. Try to sound out the individual elements of words but be unable to synthesize the single sounds into the correct word. For instance, he may sound out b/e/g and then say 'bad', of f/o/g and then say 'frog'
- 13. Mispronounces words although they are in the child's vocabulary
- 14. Confuses short vowel sounds. Reading 'bag' for 'bug' and 'lid' for 'lad'
- 15. Puts syllables in the wrong order reading 'animal' as 'aminal', 'hospital' as 'hopsital'
- 16. Foreshortens words reading 'remember' as 'rember', 'suddenly' for 'sunly' or 'spit' for 'splint'
- 17. Substitutes another word of similar meaning. e.g. 'go' for 'journey', 'Sunday' for 'Saturday', 'gave' for 'got', 'tree' for 'garden'
- 18. Substitutes the following: 'a' for 'the', 'from' for 'of', 'of' for 'for', 'then' for 'when', 'what' for 'that', 'where' for 'there', 'here' for 'her', 'where' for 'were', 'laugh' for 'lunch'
- 19. Adds little words
- 20. Ignore Punctuation
- 21. Reads in a monotone voice
- 22. Guess wildly at words regardless or whether not they make sense

Neuro-perceptual Traits

Does the child: (Please Tick)

- 1. Have geographic confusion: i.e North South East West
- 2. Have trouble putting names to things and people
- 3. Have trouble putting things in the right order
- 4. Have a vivid imagination
- 5. Have a high awareness of the environment
- 6. Have a higher level of curiosity than the average child

7. Have a high level of perception or intuitiveness
8. Have difficulty following more than one direction at a time

Strengths

Is your child particularly talented (above average) in any of the following areas: **(Please Tick ✓)**

- Sport Music Art Acting/Drama I.T
- Construction Story Telling Designing Other

If other please give details: _____

Social Traits and Interests

Please write a short comment on the following

Hobbies: _____

Sport: _____

Ambitions: _____

Social skills relating to family:

Social skills relating to friends

When you come to see us

Is there sensitive information that you would prefer not to talk about in front of your child?

- Yes
 No

If yes, we can discuss these issues while the child waits outside. You may wish to bring a book or something for them to do while they wait.

So that we can remember you and your child, we would like to take a photograph of those who attend the initial consultation. This is printed and pasted into your child's file. Photographs are not stored electronically.

Do we have your permission to take a photograph?

- Yes
 No

Thank you for taking the time to complete this questionnaire.

Completed by _____ **Date** _____