PARENT/GUARDIAN QUESTIONNAIRE FORM

Please take a few minutes to answer the questions on this form in the best way that you can. Your answers on this form will help the school staff decide what kind of educational program is best suited for your child.

This questionnaire is confidential and your responses will be shared only with professional personnel.

Child's Name:_____ Today's Date:_____

Address:_____ Phone: Home:_____
Work:_____
Town:_____ Cell:_____

Sex: ___F _____M Birthdate:_____ Birthplace:_____

Child's Social History:

a. Has child attended school before? _____Y _____N

b. If yes, name of school:_____
Dates of attendance (month/year) from _____ to _____
Number of days per week: _____2 _____3 _____4 _____5

c. Any other school experience? _____

Child's Status in Family:

a. _____oldest _____middle _____youngest _____only

b. Other children in family:

Name	Age

c. Do any of your children have difficulty in school?

Name	School	Difficulty

d. Has any family member or close relative had a significant difficulty in school?

Relationship	Nature of Difficulty

Guardians

a. ____Married _____Separated _____Divorced _____Widowed

b. **Guardian 1** Name:_____Occupation:_____
Place of Work:_____

c. **Guardian 2** Name:_____Occupation:_____
Place of Work:_____

d. Highest grade completed: (circle)

Guardian 1: 7 or less 8 9 10 11 12 / college: 1 2 3 4 5 more

Guardian 2: 7 or less 8 9 10 11 12 / college: 1 2 3 4 5 more e.

Other persons residing in the household:

Names:_____

Relationship(s):_____

f. Have there been any extraordinary events in this household (e.g., illness, moves, deaths, disaster, change in make-up of family):
_____
_____
_____
_____
_____

g. Any serious parental or family health problems?_____
_____
_____
_____
_____

Basic Medical Data:

a. Name of child's doctor:_____
Phone:_____Address:_____

b. Name of child's dentist:_____
Phone:_____Address:_____

c. Has this child had any ear/haring examination or treatment?
_____ Yes _____ No If so, when:
By whom:
Results:_____

d. Ear infections? _____Yes _____No
If yes: _____Infrequent (2-3 times per year)
_____Frequent (4 or more a year)
_____Prolonged (10 days-2 weeks)

Has your child had tubes inserted? _____Yes _____No
Date(s):_____

Do you suspect any hearing problems? _____Yes _____No

Does this child:

1. Seem to have difficulty hearing? _____Yes _____No
2. Turn up the TV louder than other members of the family? _____Yes _____No
3. Seem to favor one ear over the other? _____Yes _____No
4. Jump or appear to be more startled than others if there is a sudden noise? _____Yes _____No
5. Seem to hear you if you talk in a whisper? _____Yes _____No
6. Make you talk loudly or repeat frequently? _____Yes _____No

e. Has this child ever had a vision examination or treatment? _____Yes _____No

If so, when:_____by whom:_____
results:_____

Do you suspect any vision problems? _____Yes _____No

Does this child:

1. Seem to have difficulty seeing small lines or pictures? _____Yes _____No
2. Seem to have a problem seeing things far away? _____Yes _____No
3. Squint? _____Yes _____No
4. Wear glasses? _____Yes _____No
5. Have eyes that turn in? _____Yes _____No
6. Have eyes that turn out? _____Yes _____No
7. Sit very close to the television? _____Yes _____No
8. Rub eyes a lot? _____Yes _____No

f. At what age did this child first begin to speak? Give approximate age if you do not remember the exact age:_____

first words:_____ Two or three words together:_____
sentences:_____

Does this child stutter? _____Yes _____No

g. This child began walking at age (if guess, label as such):_____

Do you feel your child has adequate large muscle coordination. _____Yes _____No

h. Do you notice, or has a doctor reported, any of the following in this child?

_____Asthma	_____Nose bleeding	_____Nail biting
_____Constipation	_____Bed wetting	_____Epilepsy (seizures)
_____Diarrhea	_____Bed soiling	_____Lack of consciousness
_____Vomiting	_____Allergies (type)	
_____Chronic stomach Problems	_____Serious blows to the head	_____Chronic ear infections
		_____Overtired or lacking pep
_____Frequent fevers	_____Headaches	_____Diabetes

_____Sinus trouble _____Thumbsucking
_____Heart trouble _____Medical problems
_____Hyperactivity immediately after birth
_____Other physical problems or serious illnesses (explain):
_____
_____

i. Child's birth weight: _____lbs. _____oz.

j. Special considerations:

_____Cesarean _____Child rotated
_____Premature _____Cord around neck
_____Breech _____Twin (1st born, 2nd born)
_____Baby blue _____R.H. negative
_____Baby yellow _____Transfusion
_____Baby bruised
_____Other:_____

k. Special Care
_____Oxygen (how long)_____
_____Incubator (how long)_____
_____Hospital stay (how long)_____
_____Seizures or loss of consciousness_____

l. Is this child presently on medication?_____
What medication(s)_____
_____

m. Has child had any significant injuries or hospitalization?_____
_____
_____

n. Is this child prone to certain ailments? (e.g., ear infections, stomach aches, etc.?)_____
_____
_____

Please check (X) Yes, Sometimes, No, or Not Sure for each of the following statements:

It is my (our) opinion that this child:

	Yes	Sometimes	No	Not Sure
1. Has regular playmates the same age.	____	____	____	_____
2. Has difficulty getting along with other children.	____	____	____	_____
3. Has difficulty expressing self.	____	____	____	_____
4. Prefers to play with other children instead of alone.	____	____	____	_____
5. Is difficulty to understand when talking.	____	____	____	_____
6. Seems generally happy.	____	____	____	_____
7. Is frequently irritable or moody.	____	____	____	_____
8. Is upset by changes in routine.	____	____	____	_____

	Yes	Sometimes	No	Not Sure
9. Demands much individual adult attention.	___	___	___	___
10. Accepts discipline and limits.	___	___	___	___
11. Becomes confused in following more than two verbal directions at a time.	___	___	___	___
12. Has difficulty remembering things for a short time.	___	___	___	___
13. Has difficulty remembering things for a long time.	___	___	___	___
14. Is easily frustrated.	___	___	___	___
15. Cries easily.	___	___	___	___
16. Cooperates willingly.	___	___	___	___
17. Has a bad temper	___	___	___	___
18. Can use fork and spoon without help.	___	___	___	___
19. Enjoys physical activities.	___	___	___	___
20. Loses balance, trips and falls.	___	___	___	___
21. Has difficulty running.	___	___	___	___
22. Is dealing with family stress such as illness, death, or separation.	___	___	___	___

b. How old are this child's favorite playmates?_____

c. About how many hours a day does your child watch T.V._____

d. What kinds of things do you like to do with your child?_____
_____

e. Do you have any special concerns about this child?_____
_____
_____

f. Is there any information that will help us better understand this child?_____
_____
_____

g. Has your child had Special Education needs…past or present?_____

h. Would you like an individual conference with the School Psychologist or a School Adjustment Counselor to relate any information you don't feel you can include on this form?_____
_____

Do you participate in any of the following program? (Please check)

_____Social Security
_____Medicaid
_____Welfare
_____Aide for Dependent Children (AFDC)
_____Food Stamps