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EMIS No: 101021

No limits to learning

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PARENTS' QUESTIONNAIRE

DEMOGRAPHICS

Your child's full name: ____

Primary Language spoken at home: ____

Father/Stepfather/Guardian's Name: ______________________________ Age: __________

ID number ______________________________ Occupation: ______________________________

Employer ______________________________ Business phone ______________________________

Cell number: ______________________________

Mother/Stepmother/Guardian's Name: ______________________________ Age: __________

ID number ______________________________ Occupation: ______________________________

Employer ______________________________ Business phone ______________________________

Cell number: ______________________________

Significant Adults Not Living with the Child:

1. Name: ______________________________ Age: __________

Relationship to child: ____

Extent of involvement with child: ____

2. Name: ______________________________ Age: __________

Relationship to child: ____

Extent of involvement with child: ____

A: REASON FOR REFERRAL

Describe below the difficulties, which your child is currently experiencing. Please include a brief history.

____

____

____

____

Please list any known diagnoses: ____

____

Does the learner have any siblings? Do any of these siblings have any difficulties? Briefly describe

NAME OF CHILD	SEX	AGE	DIFFICULTIES

B: PREGNANCY, BIRTH AND DEVELOPMENT

Please include any significant information about your pregnancy, birth of your child and their development; you feel is important to gain a full picture of the difficulties your child is experiencing now.

____

____

____

____

____

____

____

____

Please rate your child's development on the following skills (✓ on line) during the EARLY YEARS:

	Good	Average	Poor
Walking	_____	_______	____
Running	_____	_______	____
Jumping	_____	_______	____
Skipping	_____	_______	____
Throwing	_____	_______	____
Catching	_____	_______	____
Buttoning	_____	_______	____
Tying Shoelaces	_____	_______	____
Cutting with Scissors	_____	_______	____
Athletic Ability	_____	_______	____

If you can recall the age at which your child reached the following developmental milestones, please fill in the column under age. If you cannot recall, ✓ one of the items (early, average or late)

	Age (month)	Early	Average	Late
Smiled	___________	______	________	_____
Sat without support	___________	______	________	_____
Crawled	___________	______	________	_____
Stood without support	___________	______	________	_____
Walked without assistance	___________	______	________	_____
Spoke first words (not mama/dada)	___________	______	________	_____
Said phrases	___________	______	________	_____
Pronunciation clear to strangers'	___________	______	________	_____
Spoke in sentences	___________	______	________	_____
Toilet trained	___________	______	________	_____
Rode a bike without training wheels	___________	______	________	_____
Buttoned clothing	___________	______	________	_____
Tied shoelaces	___________	______	________	_____
Named colours	___________	______	________	_____
Said alphabet in order	___________	______	________	_____
Learned to read	___________	______	________	_____

C: MEDICAL HISTORY OF CHILD

Current:

Child's present height, weight and general appearance: ____

____

Are any medications currently being taken by your child? If yes, please list and explain: __________________

____

____

____

____

Does this medication need to be administered during school hours? If so, how often ____________________

____

Any special eating problems? ____

____

Any food allergies? ____

Any other allergies that we should know of? ____

____

What does your child often complain about? (E.g. dizziness, stomachache) _______________________________

____

____

Does your child have any recurring illness/infection or physical problem of which we should be aware of e.g. Asthma, Epilepsy etc.? If so, please specify and how often.

____

____

Medical History:

Did your child have? (Please ✓ to indicate)

Measles	____	Whooping Cough	_____	Mumps	______
Chicken Pox	____	Pneumonia	_____	Diphtheria	______
Scarlet Fever	____	Polio	_____	Influenza	______

Was your child out of school during any of these diseases? Please specify, and describe your child's reaction to the illness. ____

____

____

Has your child had any other diseases? If yes, please describe ____

____

____

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

Any operations? If yes, please explain: ____

____

____

Any hospitalisation for illness other than operations? If yes, please explain: ____________________________

____

____

Any head injuries? If yes, please indicate whether your child lost consciousness and describe: ____________

____

____

Has your child displayed any of the following: persistent headaches, dizziness, insomnia, or change in weight? If yes, please explain: ____

____

____

Has your child ever had an extremely high fever? If yes, please give age and describe: ___________________

____

____

Any convulsions? If yes, please explain: ____

____

____

Any general allergies? If yes, please explain: ____

____

Any eye or ear problems? If yes, please explain: ____

____

Does your child wear glasses? ____

Has your child ever been administered oxygen? If yes, please give age and explain: ______________________

____

____

Any history of abuse? If yes, please explain severity and duration: ___________________________________

____

____

Any family history of neurological or psychiatric illness? If yes, please list and explain: ____________________

____

____

Any history of seizures in the family? ____

D: EMOTIONAL AND SOCIAL DEVELOPMENT OF CHILD

Do any of the below apply to your child? (Please ✓ to indicate)

Biting ____ Highly strung ____ Sensitive ____ Insecure ____ Tense ____ Temper tantrums ____
Anxious _____ Happy ____ Relaxed ___ Stubborn ____ Confident ____ Shyness ____
Aggression ____ Outgoing ____ Domineering ____ Competitive ____ Uncooperative ____

Other: ____

Approximate time your child goes to bed and to sleep during the week: ______________________________

Approximate time they wake up in the morning during the week: ___________________________________

Any other information that will help us understand your child better e.g. divorce, separation etc…_________

____

____

Relationships

Describe your child's relationship with his/her father/stepfather, and what forms of discipline are most often used? ____

____

____

Describe your child's relationship with his/her mother/stepmother, and what forms of discipline are most often used? ____

____

____

Describe your child's relationship with his or her brothers and sisters: ________________________________

____

____

Has your child been in contact with any unusual or odd family, friends, neighbourhood or community influences? If yes, please describe ____

Describe your child's relationships with peers and close friends: ___

Describe the neighbourhood in which your child lives (safety, opportunities for play or recreation, facilities, etc...) ___

E: STRENGTHS AND INTERESTS

What are your child's main hobbies and interests? ___

What are your child's areas of greatest accomplishment? ___

What strengths do you notice in your child?___

Any other traits or difficulties, which your child may have, which would help us to understand him/her?

F: ACADEMICS

Please ✓ on the line, which best describes your child's academic performance in each area.

THIS YEAR:

	Poor	**Weak**	**Average**	**Good**	**Excellent**
Reading	___	___	___	___	___
Arithmetic	___	___	___	___	___
Spelling	___	___	___	___	___
Writing	___	___	___	___	___

LAST YEAR:

	Poor	**Weak**	**Average**	**Good**	**Excellent**
Reading	___	___	___	___	___
Arithmetic	___	___	___	___	___
Spelling	___	___	___	___	___
Writing	___	___	___	___	___

Did your child attend pre-school? YES_____ No_____ If yes, how many years? ____________________

Age your child entered Grade 1: ____________________

Has your child repeated any grades? If yes, which one(s): ____

Please list the schools attended by your child (including pre-schools):

Name and Location	Grades	Dates Attended
____	_______	____________________
____	_______	____________________
____	_______	____________________
____	_______	____________________

G. CURRENT FUNCTIONING

Do any of the below apply to your child? (Please ✓ to indicate)

Motor Functioning:					
Muscle Weakness		Lack of coordination		Tremors in the limbs	
Fatigue		Right-left disorientation		Stiffness	
Gross motor difficulties (walking, running, jumping)		Restricted range of movement		Fine motor difficulties (cutting, writing)	
Auditory Functioning:					
Any hearing loss		Processing difficulties		Sensitive to sound	
Tactile Functioning:					
Numbness		Less sensitive to pain		Loss of sensation	
Visuo-spatial Functioning:					
Needing glasses		Colour-blind		Gets lost easily	
Language Ability:					
Problems Comprehending speech		Responding to directions/ instructions		Stutter	
Memory Processing problems:					
Sort term memory		Long term memory		Remote memory (recalling facts)	
Higher Cognitive Processes:					
General Intelligence Functioning		Difficulty coping in school		Difficulty in efficiency in planning	
Organisational Skills difficulties		Problem solving difficulties			

Personality:

Have you, relatives or friends noticed any personality change in your child? (i.e. change in mood, change in thinking, change in behaviour) ________________ .

If yes, please describe ____

____

____

Self –concept (How does the child feel about him/herself and his/her problems)? ______________________

____

____

Any changes in sexual awareness or behaviour? ____

____

How does the child function in unstructured situations (e.g. what do they do in their free time? How do they interact with their peers?) ____

____

How does your child feel about a possible change in schools? ______________________________________

____

Behaviour:

***Please* ✓ any of the following behaviours that are typical of your child:**

____ overeats	____ impulsive reactions	____ loss of control
____ suicide attempts	____ withdrawal	____ nervous habits
____ difficulty concentrating	____ vomiting	____ difficulty sleeping
____ takes too many risks	____ lazy	____ eating problems
____ aggressive behaviour	____ crying excessively	____ outbursts of anger
____ drinks alcohol	____ fitful sleep	____ nausea

Please list the names and addresses of any Professional consulted, why they were consulted, as well as the dates of the consultations.

1. Name: ____________________________________ Date: ________________________

Email address: ____

Position: ____

Reason for assessment/appointment: ____

____

Was an assessment carried out? YES_____ NO _____

Date: ____________ Type of assessment: ____

Diagnosis if applicable (Please attach report) ____

2. Name: ____________________________________ Date: ________________________

Email address: ____

Position: ____

Reason for assessment/appointment: ____

____

Was an assessment carried out? YES_____ NO _____

Date: _____________ Type of assessment: ____

Diagnosis if applicable (Please attach report) ____

3. Name: ____ Date: ___________________________

Email address: ____

Position: ____

Reason for assessment/appointment: ____

____

Was an assessment carried out? YES_____ NO _____

Date: _____________ Type of assessment: ____

Diagnosis if applicable (Please attach report) ____

Is your child currently receiving any of the below therapies on a regular basis? Please fill in details below:

	Name of therapist	How often are sessions attended
Speech and Language Therapy		
Occupational Therapy		
Physiotherapy		
Counselling/ Clinical Psychologist		
Psychiatrist		
Remedial Therapy in:		

Signature: ____ Date: _________________________

Print Name: ____

Relationship to Child: ____________________________________

All information is confidential and will only be used by appropriate personnel. The information you provide will help in the assessment of your child.

Thank you.