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Parents,

Please complete the enclosed Parent/Guardian Questionnaire. It is important to a comprehensive evaluation to have a thorough history of a child's physical and mental health, development, temperament, and educational experiences. If there are answers to questions that you would like to share confidentially before the meeting rather than in writing, please ask to speak with the school psychologist on an individual basis.

Thank you in advance for completing this questionnaire.

Michele DeVries, Ed. S.  
School Psychologist  
Educational Service Unit 10

Patrice Feller, Ed. S.  
School Psychologist  
Educational Service Unit 10

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School Psychologist  
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Dawna Sigurdson, Ed. S.  
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School Psychology Intern  
Educational Service Unit 10

## PARENT/GUARDIAN QUESTIONNAIRE

Person completing this form: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Date this form completed: \_\_\_/\_\_\_/\_\_\_ Best ways to contact you:

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Other: \_\_\_\_\_

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### CHILD INFORMATION

NAME: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ .Male .Female

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_ Teacher: \_\_\_\_\_

Primary language spoken by the child: \_\_\_\_\_ Other languages spoken by the child: \_\_\_\_\_

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### FAMILY / HOME INFORMATION

Biological mother's name: \_\_\_\_\_ Age: \_\_\_ Education: \_\_\_\_\_

Type of work: \_\_\_\_\_

Biological father's name: \_\_\_\_\_ Age: \_\_\_ Education: \_\_\_\_\_

Type of work: \_\_\_\_\_

What type of contact does the child have with biological parent/s if not living with the child? \_\_\_\_\_

List all persons in the home by first and last name:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ .Male .Female Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ .Male .Female Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ .Male .Female Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ .Male .Female Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ .Male .Female Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ .Male .Female Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ .Male .Female Relationship: \_\_\_\_\_

What is the main language spoken in the home? \_\_\_\_\_ What other languages are spoken? \_\_\_\_\_

Who else cares for the child on a regular basis (for example, grandparents, other family members, friends, babysitters, etc.)?

Explain: \_\_\_\_\_

How many hours per day does someone other than the parent/guardian care for the child? \_\_\_\_\_

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**SCHOOL HISTORY**

List previous schools the child has attended:

Preschool or grade(s) attended

Overall performance

_____	_____	.Good .Fair .Poor
_____	_____	.Good .Fair .Poor
_____	_____	.Good .Fair .Poor
_____	_____	.Good .Fair .Poor

Grades repeated: \_\_\_\_\_

Suspended in or out of school? .Yes .No \_\_\_\_\_ # of times

Any known learning problems? If yes, explain \_\_\_\_\_

List any special assistance the child has received (for example, Title 1 reading/math, speech/language, resource, ESL, gifted classes, private tutoring, etc.):

<u>Program</u>	<u>Grade(s)</u>	<u>Program</u>	<u>Grade(s)</u>
_____	_____	_____	_____
_____	_____	_____	_____

If the child is currently in any special programs, describe what is working or not working: \_\_\_\_\_

Indicate any school problems that currently apply to the child:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Poor reading skills            | <input type="checkbox"/> Forgets homework                          | <input type="checkbox"/> Does not stay seated               |
| <input type="checkbox"/> Problems with written language | <input type="checkbox"/> Starts but does not finish homework       | <input type="checkbox"/> Messy & disorganized               |
| <input type="checkbox"/> Poor handwriting               | <input type="checkbox"/> Does not do homework                      | <input type="checkbox"/> Easily distracted                  |
| <input type="checkbox"/> Poor math                      | <input type="checkbox"/> Takes excessive time to complete homework | <input type="checkbox"/> Short attention span               |
| <input type="checkbox"/> Poor performance on tests      |  | <input type="checkbox"/> Does not follow teacher directions |
| <input type="checkbox"/> Makes careless errors          |  | <input type="checkbox"/> Does not follow school rules       |
| <input type="checkbox"/> Does not ask for help          |  | <input type="checkbox"/> Refuses to go to school            |

What does the child have the most difficulty with in school? What makes these subjects/activities hard for the child?

What other learning or behavior problems interfere with the child's learning? \_\_\_\_\_

What are the child's strengths? Interests? What activities does he/she enjoy?

What would you like to see in the child's future?

If any family members, or the family, has had or currently has learning problems, please describe:

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**MEDICAL INFORMATION**

Please check the illnesses or injuries the child has had and indicate age of child:

- | <u>Age</u>  | <u>Age</u>  |
|---|---|
| <input type="checkbox"/> Measles _____  | <input type="checkbox"/> Encephalitis _____         |
| <input type="checkbox"/> Mumps _____  | <input type="checkbox"/> Polio _____                |
| <input type="checkbox"/> Chicken Pox _____                                    | <input type="checkbox"/> AIDS _____                 |
| <input type="checkbox"/> Whooping cough _____                                 | <input type="checkbox"/> Hepatitis (A, B, C) _____  |
| <input type="checkbox"/> Diphtheria _____                                     | <input type="checkbox"/> Problem with vision _____  |
| <input type="checkbox"/> Fever above 104° _____                               | <input type="checkbox"/> Problem with hearing _____ |
| <input type="checkbox"/> Strep Throat _____                                   | <input type="checkbox"/> Ear infections _____       |
| <input type="checkbox"/> Scarlet Fever _____                                  | <input type="checkbox"/> Tubes in ears _____        |
| <input type="checkbox"/> Rheumatic fever _____                                | <input type="checkbox"/> Seizures _____             |
| <input type="checkbox"/> Tuberculosis _____                                   | <input type="checkbox"/> Other Injuries _____       |
| <input type="checkbox"/> Meningitis _____                                     | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> Head Injuries _____ (describe) _____                 |   |
| <input type="checkbox"/> Coma or loss of consciousness _____ (describe) _____ |   |

Please describe hospitalizations since birth:

<u>Age</u>
_____
_____
_____

Vision: .Good .Wears glasses .Wears contacts

Date of last eye exam: \_\_\_\_\_

Hearing: .Good .Wears hearing aid(s)

Date of last hearing exam: \_\_\_\_\_

Please check the chronic health conditions the child has:

- |   |  |
|---|--|
| <input type="checkbox"/> Hay Fever        | <input type="checkbox"/> Allergies (describe) _____                    |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Stomach problems (describe) _____             |
| <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Muscle problems (describe) _____              |
| <input type="checkbox"/> Heart problems   | <input type="checkbox"/> Skin problems (describe) _____                |
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Frequent absences from school (explain) _____ |
| <input type="checkbox"/> Sinus conditions | <input type="checkbox"/> Other (explain) _____                         |

Please list any medical or psychiatric diagnoses that currently apply to the child:

\_\_\_\_\_

Please list medications the child currently takes:

Medication: _____	Dosage _____
Reason: _____	Results: _____
Medication: _____	Dosage _____
Reason: _____	Results: _____
Medication: _____	Dosage _____
Reason: _____	Results: _____
Medication: _____	Dosage _____
Reason: _____	Results: _____

Please list any current health concerns you have for the child not otherwise indicated above:

\_\_\_\_\_

\_\_\_\_\_

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**FAMILY HEALTH**

Please describe illnesses that other biological family members have had (such as seizures, diabetes, epilepsy, mental retardation, autism, ADHD, depression, alcohol/drug abuse, etc.). Include the person's relationship to the child and treatment given.

\_\_\_\_\_

\_\_\_\_\_

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**SOCIAL / EMOTIONAL**

Check all that currently apply to the child:

- |   |  |
|---|--|
| <input type="checkbox"/> Adapts to change                       | <input type="checkbox"/> Difficulty expressing feelings        |
| <input type="checkbox"/> Behavior consistent from day to day    | <input type="checkbox"/> Difficulty interacting with peers     |
| <input type="checkbox"/> Happy most of the time                 | <input type="checkbox"/> Difficulty making or keeping friends  |
| <input type="checkbox"/> Interested in many things              | <input type="checkbox"/> Frequently in fights                  |
| <input type="checkbox"/> Plays well with other children         | <input type="checkbox"/> Prefers playing with younger children |
| <input type="checkbox"/> Responsible (at age appropriate level) | <input type="checkbox"/> Requires high level of supervision    |
| <input type="checkbox"/> Responsive to people                   | <input type="checkbox"/> Unhappy most of the time              |

Please share specific discipline techniques that work at home. For whom is the child most well behaved? \_\_\_\_\_

Have there been any recent changes or stresses in the home (for example, major illnesses, deaths, changes in the family composition) that might affect the child's performance in school? \_\_\_\_\_

If the child has had or currently receives psychological counseling or therapy, please complete:

Reason for counseling: \_\_\_\_\_

Beginning and ending dates: \_\_\_\_\_

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**FAMILY MENTAL HEALTH**

If any family members, or the family, has had or currently receives psychological counseling or therapy, please complete (if you wish to share):

Reason for counseling: \_\_\_\_\_

Beginning and ending dates: \_\_\_\_\_

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**ADDITIONAL INFORMATION**

Please provide any additional current information that you believe is important:

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## DEVELOPMENTAL HISTORY

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### PREGNANCY

Number of previous pregnancies: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Length of this pregnancy: \_\_\_\_\_

How long was the pregnancy with the child under a doctor's care? \_\_\_\_\_

Check any that applied during this pregnancy and describe:

- |  |   |
|--|---|
| <input type="checkbox"/> Difficulty in conception _____  | <input type="checkbox"/> Gestational diabetes _____                 |
| <input type="checkbox"/> Threatened miscarriage _____  | <input type="checkbox"/> Injury _____                               |
| <input type="checkbox"/> Hospitalization during pregnancy _____                                  | <input type="checkbox"/> Kidney disease _____                       |
| <input type="checkbox"/> Physical restrictions during pregnancy _____                            | <input type="checkbox"/> Measles (exposed to / or contracted) _____ |
| <input type="checkbox"/> Anemia _____  | <input type="checkbox"/> Rh incompatibility _____                   |
| <input type="checkbox"/> Elevated Blood Pressure _____   | <input type="checkbox"/> Toxemia _____                              |
| <input type="checkbox"/> Emotional distress/stressful events _____                               | <input type="checkbox"/> Vaginal bleeding _____                     |
| <input type="checkbox"/> Excessive swelling _____  | <input type="checkbox"/> Other illnesses or problems _____          |
| <input type="checkbox"/> Excessive vomiting _____  |   |
| <input type="checkbox"/> Cigarettes used during pregnancy (indicate how often or how much) _____ |   |
| <input type="checkbox"/> Alcohol used during pregnancy (indicate how often or how much) _____    |   |
| <input type="checkbox"/> Drugs used during pregnancy _____                                       |   |

<u>Type</u>	<u>Frequency</u>	<u>Prescription</u>
_____	_____	.Yes .No
_____	_____	.Yes .No
_____	_____	.Yes .No

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### BIRTH HISTORY

Length of labor: \_\_\_\_\_ hours

Child's birth weight: \_\_\_\_ lbs \_\_\_\_ oz

Child's condition at birth \_\_\_\_\_ What was the child's Apgar score (if known)? \_\_\_\_\_

Length of child's stay at hospital: \_\_\_\_\_

Mother's condition: \_\_\_\_\_ Length of mother's stay at hospital: \_\_\_\_\_

At the child's birth, what was the mother's age? \_\_\_\_\_ Father's age? \_\_\_\_\_

Check all that applied and describe:

- Mother given medication during childbirth: \_\_\_\_\_
- Mother under anesthesia during childbirth: \_\_\_\_\_ .General .Spinal .Local
- Labor induced (explain): \_\_\_\_\_
- Delivery by forceps: \_\_\_\_\_
- Delivery unusual in any way (explain): \_\_\_\_\_
- Caesarean section (indicate reason): \_\_\_\_\_
- Multiple birth: \_\_\_\_\_

Check all that applied to the child at birth or during the first week:

- |   |  |
|---|--|
| <input type="checkbox"/> Anoxia               | <input type="checkbox"/> Abnormal color: blue or yellow (circle one) |
| <input type="checkbox"/> Breathing problems   | <input type="checkbox"/> Jaundice                                    |
| <input type="checkbox"/> Cord around the neck | <input type="checkbox"/> Feeding problems                            |
| <input type="checkbox"/> Oxygen used          |  |

