LEARNING SOLUTIONS FOR LEARNING SUCCESS, LLC
2 Main Street
Florence, MA 01062-3500
(413) 584-0265 · (413) 584-2031
learningsolutions@lslsllc.com

PARENT QUESTIONNAIRE

TODAY'S DATE:_____

CHILD'S NAME:_____DATE OF BIRTH:_____
HOME ADDRESS:_____
_____

PARENT'S NAME:_____
RELATIONSHIP TO CHILD:_____
TELEPHONE HOME:_____WORK:_____CELL:_____
EMAIL:_____

PARENT'S NAME:_____
RELATIONSHIP TO CHILD:_____
TELEPHONE HOME:_____WORK:_____CELL:_____
EMAIL:_____

NAME OF SCHOOL:_____GRADE:_____
SCHOOL ADDRESS:_____
TEACHER(S):_____

REFERRED BY: _____
ADDRESS:_____
TELEPHONE:_____

PHYSICIAN'S NAME:_____
ADDRESS:_____
TELEPHONE:_____FAX:_____

Additional Professional Agencies involved with your student:_____
_____
Has this child had previous evaluations outside of school? □ Yes □ No
If so, where and when**?** _____

Attach any available report(s) and IEPS:_____

Are there any IEP or 504 Team meetings coming up soon? If so when? _____

Has this child received any special treatments (diets, medications, psychological counseling, psychiatric help, etc.) outside of school? □ Yes □ No

If so, please describe below:

APPROXIMATE DATE(S)	TYPE(S) OF TREATMENT (include name of any medicine you remember)

Did this child attend a preschool/nursery school? □ Yes □ No
If so, were any problems with behavior noted? □ Yes □ No
Were any problems with learning noted? □ Yes □ No
Was this child ever retained in a grade? □ Yes □ No
If so, when?_____
What is the principal language spoken at home?_____
Indicate others that are used sometimes_____

If the child is receiving services through his or her school, what has been tried?

_____
_____
_____
_____
_____

BACKGROUND QUESTIONS

Please answer the following questions as completely as you feel you need to. You can attach additional pages as necessary.

PROBLEMS:

Please describe the problems that are currently troubling you and your child and what kind of help you are seeking:

_____
_____
_____
_____
_____
_____
_____

When was the problem first noticed?

_____
_____
_____
_____
_____

Do you find anything at home that helps?

_____
_____
_____
_____
_____

What seems to make the problem worse?

_____
_____
_____

_____

_____

TALENTS, SKILLS, PLEASURES

What are your student's special interests, talents, loves and pleasures?

_____

_____

_____

_____

_____

_____

_____

What is special/enjoyable/delightful about this child?

_____

_____

_____

_____

_____

What does he or she do well?

_____

_____

_____

_____

_____

What does he or she like to do for play/recreation (especially sports)?

_____

_____

_____

_____

_____

FAMILY INFORMATION

Parent's name_____
Present age _____School level completed_____
Present occupation_____
General health_____

Parent's name_____
Present age_____ School level completed_____
Present occupation_____
General health_____

Child's Siblings:
Brother(s): Age(s)_____
_____
Sister(s): Age(s) _____
_____

Please check any of the following that are true of this child:
□ Was adopted □ Is a foster child □ Is a stepchild
If adopted, when: _____
If a foster child, since when: _____
If a stepchild, when was the marriage: _____
Parents are □ married □ separated or □ divorced. □ One or □ both parent(s) are deceased.
If so, child lives mainly with (check one or more):
□ Mother □ Stepmother □ Grandparent(s)
□ Father □ Stepfather □ Other_____

Please put an X in the column of the family member(s) who have or have had each problem. If more than one brother or sister has or has had one of these difficulties, put an X for each one in the appropriate column. The "Others" column (for family members such as cousins, aunts, uncles, grandparents) should be used in the same way.

FAMILY HISTORY	Child's Mother	Child's Father	Child's Brother(s)	Child's Sister(s)	Others (specify)
Hyperactive as a child					
Trouble learning to read					
Trouble with arithmetic					
Trouble with writing					
Kept back in school					
Speech or language problems					
Behavior problems in childhood					
In trouble as a teenager					
Depression					
Anxiety					

Other mental illness					
Drinking problem or drug abuse					

Please read each list, then put an X in the appropriate column following each item.

POSSIBLE PREGNANCY PROBLEMS	TRUE	NOT TRUE	CANNOT SAY
Had infertility treatments for this pregnancy			
Had bleeding during first three months			
Had bleeding during second three months			
Had bleeding during last three months			
Gained 30 or more lbs. (14 kgs.) (specify_____)			
Had toxemia			
Had to take medications*			
Vomited often			
Got hurt or injured			
Gained less than 15 lbs. (7 kgs.) (specify_____)			
Took narcotic drugs			
Drank much alcohol			
Had previous miscarriages			
Had previous premature baby(ies)			
Had an infection			
Smoked one pack (or more) of cigarettes a day			
Labor lasted longer than 12 hours			
Had a Caesarean section			
Had a difficult delivery			
a. forceps?			
b. Pitocin used?			
Was put to sleep for delivery			
Labor lasted less than 2 hours			
Was a multiple birth			
Length of pregnancy_____months			

*Specify any medications:
1._____
2._____
3._____

Other pregnancy problems/illnesses:
1._____
2._____
3._____

NEWBORN INFANT PROBLEMS	TRUE	NOT TRUE	CANNOT SAY
Born with cord around neck			
Injured during birth			
Had trouble breathing			
Got yellow (jaundice)			

Turned blue (cyanosis)			
Had an infection			
NEWBORN INFANT PROBLEMS	TRUE	NOT TRUE	CANNOT SAY
Was given medications			
Had seizures (fits, convulsions)			
Had diarrhea			
Needed oxygen			
Was in hospital more than 7 days			
Gagged often			
Vomited often			
Born with heart defect			
Born with other defect(s)			
Had trouble sucking			
Had skin problems			
Was very jittery			
Baby's birth weight _____lbs. □ kgs. □ _____ins. □ cms. □			

Please list any other problems:_____

MEDICAL HISTORY	Never	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	4-5 years	5-7 years	Since 7 years (please indicate what age)
Ear infection(s)/myringotomy tubes											
Rashes or skin problems											
Meningitis											
Seizures (convulsions) or spells											
High fevers (over 103° F or 39° C)											
Diabetes											
Pneumonia											
Asthma											
Sinus Problems											
Chronic colds											
HIV/AIDS											
Encephalitis											
Tonsillitis											
Tonsillectomy											
Adenoidectomy											
Mastoidectomy											

Diphtheria											
Croup											
MEDICAL HISTORY	Never	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	4-5 years	5-7 years	Since 7 years (please indicate what age)
Influenza											
Polio											
Whooping cough											
Slow weight gain											
Trouble with ears or hearing											
Trouble with eyes or vision											
Bowel problems											
Hospitalization(s)*											
Surgery (operations)*											
Serious injury(ies)											
Head injury(ies)											
Food allergies											
What types of food? (please list)											
Check if Anaphylactic											
Other allergies											
Anemia (low blood count)											
Lead poisoning											
Other poisoning or overdose											
Heart problems											
Kidney or urinary problems											
Got sick after an immunization											
Other important illnesses (specify):											
a.											
b.											
Medications used over a long period (specify):											
a.											
b.											

*Please give reasons for hospitalizations or surgery:_____

Please put an X next to each item under the column giving the age at which this "milestone" first occurred.

EARLY DEVELOPMENT	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	4-5 years	5-6 years	Cannot do as of yet
Sat up without help										
Crawled										
Walked alone (10-15 steps)										
Walked upstairs										
Rode a tricycle										
Caught a big ball										
Spoke first words										
Put words together (Daddy bye-bye, home, etc.)										
Spoke 2-3 word sentences										
Spoke clearly so strangers understood										
Used fingers to feed self										
Used a spoon										
Fully bowel trained										
Fully bladder trained										
Able to dress self										
Able to tie shoelaces										
Able to separate easily from parent (for school, play, etc.)										

Please mark yes or no for the following questions.

SENSORY QUESTIONS	YES	NO
Is your child overly sensitive to touch, texture, movement, sights or sounds?		
Is your child under-reactive to touch, texture, movement, sights or sounds?		
Does your child display an activity level that is unusually high or unusually low?		
Does your child have difficulty with memory or getting organized?		

Speech and Language

IF YOUR CHILD IS BELOW THE AGE OF 6, PLEASE COMPLETE THE FOLLOWING 4 SECTIONS

SECTION 1
How much did the child vocalize during his/her first 1-2 months? _____
How much did the child babble during his/her first six months? _____
When did s/he speak his/her first words meaningfully (not in imitation)? _____
What were they? _____

Please answer the following with "yes" or "no" for each year.

	1st year	2nd year	3rd year
Attends to sounds			
Responds when spoken to			
Responds to noises and voices			
Normal amount of crying			
Normal amount of laughing			
Presence of head banging or foot stomping			
Yelling or screeching to attract attention or express annoyance			
Marked alertness to gesture, facial expression and movement			

SECTION 2
At what age did your child:

Respond to his/her name? _____
Begin to use two-word phrases?_____
Begin using sentences?_____
If your child is under 5 years of age, estimate how many words are in the child's vocabulary (check one): Under 25____ 25-75____ 75-150____ Over 150____
Has the child's vocabulary increased or decreased since the problem was first noticed?_____
Does s/he use speech? Frequently _____ Occasionally_____ Seldom_____ Never_____
Does s/he prefer to use: Sentences _____ Phrases_____ One or two words_____
Sounds_____ Gestures_____
If the child prefers gestures to speak, give examples: _____
_____

SECTION 3
How well can she/he be understood by:

Parent Always___Usually___Sometimes___Rarely___Never___
Brothers, Sisters, Playmates Always___Usually___Sometimes___Rarely___Never___
Relatives and strangers Always___Usually___Sometimes___Rarely___Never___
How well does s/he understand
what is said to him/her? Always___Usually___Sometimes___Rarely___Never___
Will the child follow simple directions such as, "Get me the _____"? Yes___ No___
Has your child ever had an ear infection? Yes___ No___
Has the child ever worn a hearing aid? Yes___ No___
If yes, which ear? Right___ Left___ Both___
How long? ____ Hours per day? ____ Does it seem to help? Yes___ No___

If you answered yes to any question, please explain your answer here:

_____
_____
_____

SECTION 4

FEEDING QUESTIONS	YES	NO
Do/did you have difficulty feeding your child?		
Does/did your child have problems transitioning from a bottle to table food?		
Does your child have difficulty sucking through a straw or taking food from a spoon?		
Does your child resist certain types of food?		
Does your child resist hot or cold foods?		
Does your child eat all textures of food, e.g., thin (pudding, yogurt), crunchy (crackers, cookies), chewy (popcorn chicken, licorice, marshmallows), and very chewy foods (meats)?		
Does your child prefer to eat foods that are bland?		
Does your child drool a lot during meals?		

If you answered yes to any question, please explain your answer here:

_____
_____
_____

Please indicate any other concerns you have about your child that you have not had an opportunity to talk about:

_____

_____

_____

_____

_____

_____