Literacy Care

Parent/Guardian Questionnaire

Thank you for taking the time to answer the following questions. The information you provide about your child is essential.

This questionnaire along with the Teacher Questionnaire (filled out by the Classroom Teacher) should be handed to our administration staff on arrival. This form can also be filled out and submitted on-line.

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

Child's SURNAME: _____

Child's FIRST NAME: _____

Date of Birth: _____ / _____ / _____

Gender Description: _____

Current School: _____

Thank You for Your Cooperation

Unit 14, 32 Park Road, Milton Qld 4064 PO Box 1536 Milton Qld 4064
(07) 3369 3369 3369 3370 cdn@cd.net.au or jason@cd.net.au www.cd.net.au or www.literacycare.com

Strengths and Interests?

Is your child average or better in any of the following areas: (Please Tick ⬟)

Sport ☐	Music ☐	Art ☐	Acting/Drama ☐
I.T ☐	Construction ☐	Story Telling ☐	Designing ☐
High Level of Perception and Intuition ☐	Vivid Imagination ☐	High awareness of the environment ☐	Just a bit different in a wonderful way ☐

Please write a short comment on the following:

Hobbies: _____

Sport:_____

Ambitions:_____

Social skills relating to family:_____

Social skills relating to friends:_____

Questions, Concerns Outcomes

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

1. Not at All	2. Somewhat	3. Moderately	4. Quite a Lot	5. Extremely

Parent 1 ***1_____2_____3_____4_____5***

Parent 2 ***1_____2_____3_____4_____5***

What questions would you like answered about your child?

_____

_____

_____

_____

What outcome(s) would you like Literacy Care to achieve for your child?

_____

_____

_____

Do you believe your child's learning and development has suffered from or has been negatively influenced by any of the following?

	Please ✓✗	If Yes, Briefly Explain
Anxiety	☐	
Attention and Concentration	☐	
Sleep Patterns	☐	
Diet and Eating Habits	☐	
Developmental Problems	☐	
Major Accidents	☐	
Major Illnesses	☐	
Major Injuries	☐	
Family Conflict	☐	
Abuse	☐	

When your child was between 18 months and 5 years, were you concerned about any of the following?

	Please ✓✗
Early motor development (sitting, walking, running, kicking)?	☐
Early language (talking and understanding)?	☐
Early social development (eye contact, play, friends)?	☐
Early learning (e.g. colours, shapes, drawing)?	☐

Diagnosed Conditions and Medication

Has your child been formally (by a Medical Practitioner, Psychologist or other Professional) diagnosed with any of the following? (Please Tick ✓)

Attention Deficit Hyperactivity Disorder	☐	Non Verbal Learning Disability	☐
Oppositional Defiant Disorder	☐	Anxiety Disorder	☐
Autistic Spectrum Disorder	☐	Aspergers Syndrome	☐
Dyslexia	☐	Dyspraxia	☐
Dysgraphia	☐	Dyscalculia	☐
Vision Difficulties	☐	Hearing Difficulties	☐

Other: (Please Describe)_____

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

If Yes, please give details: _____

Hereditary Factors

Does anybody in the family (siblings, parents, grandparents, aunts, etc have problems **similar** to, or the **same as** your child?	☐ Yes	☐ No

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?	☐ Yes	☐ No

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 [✓]**	**Who?**
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)			

Academic and Scholastic Interventions and Information

Please name/describe all educational programs and or interventions in which your child has participated

_____

_____

_____

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

Well Below Average Below Average Average Above Average Well Above Average

Which is your child's best subject?

_____

Fill out the Following Relative to the Child's Reading, Spelling and Writing and general behaviour in classroom

Complaints by the child or observations by adults (parents/teachers) (Please ✓)

1. Words moving on the page ☐
2. Colours appearing on the page ☐
3. Hard to read under florescent light ☐
4. Bothered by glare ☐
5. Premature fatigue ☐
6. Can't concentrate on the teacher's voice ☐
7. Forgets instructions almost straightaway ☐
8. Relies on watching other children to figure out what to do ☐
9. Low written output ☐
10. Has great ideas but can't put them into written words ☐

When you come to see us

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

- ❑ Yes
- ❑ No

2. 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. Do we have your permission to take a photograph of you together with your child?

- ❑ Yes
- ❑ No

Thank you for taking the time to complete this questionnaire.

Completed by: (Please Print Name)

_____

Signature: _____***: Date:*** _____ / _____ / _____