Parent/Guardian Questionnaire

Please Read Before Completing Questionnaire

- Thank you for taking the time to answer the following questions. The information you provide about your child is essential.
- This form needs to be printed and filled out by hand. It can be scanned and emailed or brought along to the initial consultation.
- The Questionnaire is divided into four sections. If you have been referred by a practitioner at the CDN then only complete Sections 3 and 4. If you are new to CDN please complete all four sections.
- Please ensure this questionnaire is submitted along with the Teacher Questionnaire.

SECTION 1: PERSONAL DETAILS:

Child's Full Name: _____

Male / Female (Please Circle) Date of Birth: __ __ / __ __ / __ __ __ __

Parent / Guardian 1 (Full Name): _____

Contact Number: (Parent 1): _____

Email (Parent 1): _____

Occupation of Parent / Guardian 1: _____

Parent / Guardian 2 (Full Name): _____

Contact Number (Parent 2): _____

Occupation of Parent / Guardian 2: _____

Email (Parent 2): _____

If Parents are Separated Please Indicate (✓): ❒

Postal Address: (No. and Street or PO Box) _____

Suburb/Town/City: _____ Post Code: _____

How far from the CDN does the child live (or go to school) in Travel Time: _____

School: _____

Year of Schooling (incl Prep): _____ Age in Years: _____ Months: _____

Referred by (please✓): ❒ Practitioner (other than GP): _____ ❒ Friend?

Please tick only if you do not wish to receive a quarterly newsletter from the Literacy Foundation for Children with articles on learning and literacy: Yes ❒

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SECTION 2: REFERRAL BY EXTERNAL CLINICIAN (NOT AT CDN):

Child's Full Name: _____ Date of Birth: _____

Referral Information

1. Were you referred by a clinician who is at CDN (Please Tick ✓) ❒ Yes (go to SECTION 3)
   ❒ No (complete SECTION 2)

   a Name of referring clinician: _____

   b Do you have a referral letter or report? (Please Tick ✓) ❒ Yes or ❒ No (Please note: a referral letter is not required but please bring letter/report if you have one)

   c What was the main reason your saw the clinician? _____

2. Do you intend seeing another clinician at the CDN (Please Tick ✓) ❒ Yes or ❒ No

   If so, who? _____

   When do you expect to see this professional? _____

Diagnosed Conditions and Medication

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

Attention Deficit Hyperactivity Disorder	❒	Non-Verbal Learning Disability	❒
Oppositional Defiant Disorder	❒	Anxiety Disorder	❒
Autistic Spectrum Disorder	❒	Working Memory Difficulties	❒
Dyslexia	❒	Dyspraxia	❒
Dysgraphia	❒	Dyscalculia	❒
Vision Difficulties	❒	Hearing Difficulties	❒

2. Is the child on any medication relative to learning or behaviour? (Tick ✓) ❒ Yes or ❒ No

   If Yes, please give details: _____

(Continue to SECTION 3)

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SECTION 3: LITERACY AND LEARNING QUESTIONS:

Child's Full Name: _____ Date of Birth: _____

Strengths and Interests?

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

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

Please write a short comment on the following:

Organizational Skills: _____

Ambitions: _____

Non-Academic Interests: _____

_____

Social skills relating to family: _____

_____

Social skills relating to friends: _____

_____

Questions, Concerns, Outcomes

Overall, how concerned (worried) are you about your child? Use the Scale below to help you answer

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

_____

_____

_____

_____

(turn the page)

Do you believe your child's learning and development 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	❒	

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?

	Currently [✓]	In the Past [✓]	Name:
Paediatrician	❒	❒	
Child Psychiatrist	❒	❒	
Occupational Therapist	❒	❒	
Speech Pathologist	❒	❒	
Psychologist	❒	❒	
Social Worker/Counselor	❒	❒	
School Guidance Officer	❒	❒	
Learning Support Teacher	❒	❒	
Home Tutor	❒	❒	
Other (e.g. Naturopath)	❒	❒	

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Academic and Scholastic Interventions and Information

Please name/describe all educational programs and or interventions in which your child has participated. If none, please write 'Nil'

_____

_____

_____

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

Well Below Average Below Average Average Above Average Well Above Average

Which is your child's best subject? _____

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 - Please briefly state this so it can be avoided _____
   ❒ 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. Usually the photo is of parents/guardians and child together. This photograph is pasted into your child's electronic file. Do we have your permission to take a photograph of you together with your child? (Please feel free to submit a photo of your choice).

   ❒ Yes
   ❒ No

(Continue to SECTION 4)

(turn the page)

SECTION 4:

Child's Full Name: _____ Date of Birth: _____

Completed by: (Please Print Name) _____

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

Thank you for taking the time to complete this questionnaire.