



PARENT QUESTIONNAIRE

Thank you for completing this form as completely as possible. All information on this form is strictly confidential and protected by the school. Please return to:

De LaSalle Academy
8871 De LaSalle Academy Way or **lmoreau@delasallefm.org**
Ft. Myers, FL 33912

STUDENT'S NAME _____ DATE OF BIRTH _____

GRADE LEVEL _____ GENDER M F AGE _____ years _____ months

FORM COMPLETED BY _____ Date completed: _____

RELATIONSHIP TO CHILD _____

ADDRESS: _____ HOME PH: _____

_____ CELL PH: _____

EMAIL: _____

In what area(s) do you have concerns for your child? Academic Social Behavioral

Please describe your primary concerns: _____

Please describe your child's strengths: _____

Has your child been evaluated by a school psychologist or private psychologist? Yes No

Name of private psychologist or school district that provided the most recent testing: _____

PLEASE ATTACH ALL PSYCHOLOGICAL-EDUCATIONAL EVALUATIONS RECEIVED WITHIN THE LAST 3 YEARS, or THE MOST RECENT ON FILE.

What diagnosis was indicated at the time of the most recent evaluation?: _____

Does your child have a current IEP in the public school system? Yes No

Is your child currently receiving educational support services? Yes No Privately In School

If yes, what kind: Tutoring OT Speech Counseling Other: _____

SCHOOL PERFORMANCE

Please complete for students in Grade 1 and higher. Below Grade 1, please continue with the Behavior Inventory section on the next page. Please check the response that, *in your view*, best describes your child's current academic functioning.

<u>SKILLS</u>	<u>Don't Know</u>	<u>Below Average</u>	<u>Average</u>	<u>Above Average</u>
Reading				
Reading words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speed (fluency and accuracy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spelling				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Math				
Calculation (can add, subtract, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Applications (e.g. word problems)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Automaticity (remembers math facts easily)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing				
Mechanics (Grammar/punctuation, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Content (ability to communicate ideas in writing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neatness (including letter formation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check the response that, in your opinion, best describes your child's study habits and organization of work.

Organization/Study Habits	<u>Never or Rarely</u>	<u>Sometimes</u>	<u>Often</u>	<u>Very Often</u>
Writes directions/instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Completes homework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remembers assignments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knows what and how to study	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands in completed work the next day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knows where school materials are located	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to pace long-term projects/assignments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to plan out work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

At what time is homework usually done? As soon as s/he comes home from school Before dinner After dinner
 In the morning After school care program No particular routine

Average time spent on homework: 15 min 30 min 1 hour 1-2 hours 2-3 hours

Generally completes homework independently with some assistance with much assistance

Who typically provides homework assistance or monitoring when it is needed? _____

Has your child ever repeated a grade? No Yes If yes, which grade(s): _____

PLEASE NOTE ANY OTHER INFORMATION THAT WOULD HELP SCHOOL PERSONNEL UNDERSTAND YOUR CHILD'S ACADEMIC NEEDS:

BEHAVIOR INVENTORY

Complete for all students. Please check the responses that best describe your child's behavior patterns.

	Never or <u>Rarely</u>	<u>Sometimes</u>	<u>Often</u>	Very <u>Often</u>
ATTENTION				
Does not pay close attention to details/Makes careless mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty maintaining attention for longer periods of time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seems to not listen/has difficulty following instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not finish what is started (i.e., schoolwork or chores), however, not due to the refusal to understand the instructions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unorganized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reluctant to engage in challenging tasks requiring prolonged mental effort (i.e., schoolwork, homework, or chores)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loses things necessary for tasks and/or activities (i.e., toys, books)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distractible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ACTIVITY				
Fidgets or squirms in seat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaves seat in classroom or in other situations in which remaining seated is expected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runs about or climbs excessively when s/he knows s/he should not	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty playing quietly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is "on the go" or acts as if "driven by motor"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talks a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IMPULSIVITY				
Blurts out answers before questions have been completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty awaiting his or her turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does things without considering the consequences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interrupts or intrudes on others (i.e., discussions, games, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OPPOSITION				
Loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Argues with adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refuses to obey rules or commands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deliberately annoys people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blames others for his or her mistakes or behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is touchy or easily annoyed by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SOMATIC CONCERNS				
Seems sad, unhappy or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cries or whines easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seems nervous or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial ticks or twitches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drowsy or sleeping during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seems anxious or worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomachaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PEER INTERACTIONS/SOCIAL SKILLS				
Has a best friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Makes friends easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shows good sportsmanship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is bossy – needs to be in control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is physically aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is verbally aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prefers to play by him/herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets teased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teases others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Prefers peers who are: Same age Older Younger Opposite gender

Does your child have: trouble getting into bed trouble falling asleep trouble staying asleep none of these

What is your child's bedtime? _____ At what time does your child fall asleep? _____

Please indicate whether your child presents any **PROBLEMS WITH COMPLIANCE TO INSTRUCTIONS, COMMANDS OR RULES** in the following situations by *circling* the response that is most applicable. If you answer "yes", then circle the number that most appropriately indicates the severity of the problem.

SITUATIONS	NO / YES		MILD					SEVERE				
	No	Yes	1	2	3	4	5	6	7	8	9	
While playing alone	No	Yes	1	2	3	4	5	6	7	8	9	
While playing with others	No	Yes	1	2	3	4	5	6	7	8	9	
At mealtimes	No	Yes	1	2	3	4	5	6	7	8	9	
While getting dressed	No	Yes	1	2	3	4	5	6	7	8	9	
Washing and bathing	No	Yes	1	2	3	4	5	6	7	8	9	
While you are on the telephone	No	Yes	1	2	3	4	5	6	7	8	9	
While watching television	No	Yes	1	2	3	4	5	6	7	8	9	
When visitors are in your home	No	Yes	1	2	3	4	5	6	7	8	9	
While you are visiting someone's home	No	Yes	1	2	3	4	5	6	7	8	9	
In public places (restaurants, church, etc)	No	Yes	1	2	3	4	5	6	7	8	9	
When father is home	No	Yes	1	2	3	4	5	6	7	8	9	
When asked to do chores	No	Yes	1	2	3	4	5	6	7	8	9	
When asked to do homework	No	Yes	1	2	3	4	5	6	7	8	9	
At bedtime	No	Yes	1	2	3	4	5	6	7	8	9	
While in the car	No	Yes	1	2	3	4	5	6	7	8	9	
When with a babysitter	No	Yes	1	2	3	4	5	6	7	8	9	

DEVELOPMENTAL SKILLS

	<u>Don't Know</u>	<u>Below Average</u>	<u>Average</u>	<u>Above Average</u>
Using a Pencil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tying Shoelaces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using silverware	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Playing most sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Riding a bicycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pronouncing words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clearly expressing ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telling stories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding stories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remembering facts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remembering what s/he just heard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memorization of new content	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH HISTORY

THE FOLLOWING QUESTIONS PERTAIN TO ANY HEALTH PROBLEMS YOUR CHILD MAY HAVE EXPERIENCED. Please fill in the most appropriate response. Has this child had any of the following health conditions?

	NO	YES		NO	YES
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>
Ear infections (chronic)	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis (chronic)	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Head trauma w/loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Loss of consciousness without head trauma	<input type="checkbox"/>	<input type="checkbox"/>			

Has your child been hospitalized? No Yes If yes, list reason and age of child at the time:

Has your child had any surgeries? No Yes If yes, list surgery and age of child at the time:

Is your child allergic to any medications, foods, plants, etc.? No Yes If yes, please list:

Does your child have any physical limitations that the school should be aware of? No Yes If yes, please list:

Is your child currently taking prescription or regularly used over the counter medication? No Yes

Please list the medications that your child is currently taking:

Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____

Please list the names of your child's health care providers, including pediatrician, neurologist, psychologist, therapists:

NAME

TYPE OF PROVIDER

_____	_____
_____	_____
_____	_____
_____	_____

HOME ENVIRONMENT

CURRENT MARITAL STATUS OF PARENTS

	NO	YES	HOW LONG?
Married	<input type="checkbox"/>	<input type="checkbox"/>	_____
Divorced	<input type="checkbox"/>	<input type="checkbox"/>	_____
Separated	<input type="checkbox"/>	<input type="checkbox"/>	_____
Remarried			
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____

CHILD'S SIBLINGS: *Check if sibling lives with this child.*

NAME	AGE	M/F
<input type="checkbox"/> _____		
<input type="checkbox"/> _____		
<input type="checkbox"/> _____		
<input type="checkbox"/> _____		
<input type="checkbox"/> _____		

Who lives with this child? Mother Father Step-mother Step-father Siblings listed above

Please describe any court-ordered custody or visitation arrangements, if applicable:

Is this child adopted? Yes No If yes, date of adoption: _____

Is the child aware of the adoption? Yes No

PLEASE INCLUDE ANY OTHER INFORMATION THAT YOU FEEL WILL HELP SCHOOL PERSONNEL TO UNDERSTAND YOUR CHILD'S ACADEMIC, BEHAVIORAL, AND SOCIAL NEEDS.