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
6401 Techster Blvd.
Ft. Myers, FL 33966

or lriti@delasallefm.org

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.

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

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

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

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 Rarely	Sometimes	Often	Very Often
ATTENTION				
Does not pay close attention to details/Makes careless mistakes	□	□	□	□
Has difficulty maintaining attention for longer periods of time	□	□	□	□
Seems to not listen/has difficulty following instructions	□	□	□	□
Does not finish what is started (i.e., schoolwork or chores), however, not due to the refusal too understand the instructions.	□	□	□	□
Unorganized	□	□	□	□
Reluctant to engage in challenging tasks requiring prolonged mental effort (i.e., schoolwork, homework, or chores)	□	□	□	□
Loses things necessary for tasks and/or activities (i.e., toys, books)	□	□	□	□
Distractible	□	□	□	□
ACTIVITY				
Fidgets or squirms in seat	□	□	□	□
Leaves seat in classroom or in other situations in which remaining seated is expected	□	□	□	□
Runs about or climbs excessively when s/he knows s/he should not	□	□	□	□
Has difficulty playing quietly	□	□	□	□
Is "on the go" or acts as if "driven by motor"	□	□	□	□
Talks a lot	□	□	□	□
IMPULSIVITY				
Blurts out answers before questions have been completed	□	□	□	□
Has difficulty awaiting his or her turn	□	□	□	□
Does things without considering the consequences	□	□	□	□
Interrupts or intrudes on others (i.e., discussions, games, etc.)	□	□	□	□
OPPOSITION				
Loses temper	□	□	□	□
Argues with adults	□	□	□	□
Refuses to obey rules or commands	□	□	□	□
Deliberately annoys people	□	□	□	□
Blames others for his or her mistakes or behavior	□	□	□	□
Is touchy or easily annoyed by others	□	□	□	□
SOMATIC CONCERNS				
Seems sad, unhappy or depressed	□	□	□	□
Cries or whines easily	□	□	□	□
Seems nervous or irritable	□	□	□	□
Facial ticks or twitches	□	□	□	□
Decreased appetite	□	□	□	□
Drowsy or sleeping during the day	□	□	□	□
Seems anxious or worried	□	□	□	□
Headaches	□	□	□	□
Stomachaches	□	□	□	□
PEER INTERACTIONS/SOCIAL SKILLS				
Has a best friend	□	□	□	□
Makes friends easily	□	□	□	□
Shows good sportsmanship	□	□	□	□
Is bossy – needs to be in control	□	□	□	□
Is physically aggressive	□	□	□	□
Is verbally aggressive	□	□	□	□
Prefers to play by him/herself	□	□	□	□
Gets teased	□	□	□	□
Teases others	□	□	□	□

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**
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

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

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	□	□	Heart problems	□	□
Ear infections (chronic)	□	□	Seizures	□	□
Vision problems	□	□	Sinusitis (chronic)	□	□
Hearing problems	□	□	Incontinence	□	□
Head trauma w/loss of consciousness	□	□	Other_____	□	□
Loss of consciousness without head trauma	□	□			

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	□	□	
Divorced	□	□	
Separated	□	□	
Remarried			
Mother	□	□	
Father	□	□	

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

	NAME	AGE	M/F
□			
□			
□			
□			
□			
□			

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.