

PARENT QUESTIONNAIRE (K-12)

This information is **CONFIDENTIAL** and will be used by **BOCES** staff and appropriate School Staff for assessment and educational planning. *If completing in fillable format, you will need to save it to your computer prior to making changes, fill in questions, save again to your desktop, then e-mail/fax to the designated person.*

CHILD'S LEGAL NAME _____ DATE OF BIRTH _____

ADDRESS _____

PLACE OF BIRTH _____ LENGTH OF TIME IN USA _____

NAME OF SCHOOL _____ TEACHER'S NAME(S) _____

NAME OF PERSON AND YOUR RELATIONSHIP COMPLETING THIS FORM _____

YOUR CHILD'S SCHOOL E-MAIL ADDRESS: _____

Child Strengths and Interests _____

What is your child good at and like to play with? _____

What does your child like? _____

What does your child dislike? _____

Parent Information _____

Mother's name _____ Stepmother? No Yes

Language(s) spoken (primary listed first) _____

Address _____ City _____ Zip Code _____

Cell Phone _____ Work Phone _____ E-mail Address _____

Occupation _____ Employer _____

How long with present employer _____ Highest Grade completed _____

Father's name _____ Stepfather? No Yes

Language(s) spoken (primary listed first) _____

Address _____ City _____ Zip Code _____

Cell Phone _____ Work Phone _____ E-mail Address _____

Occupation _____ Employer _____

How long with present employer _____ Highest Grade completed _____

Other custodial parent (If applicable) _____ Language(s) spoken _____

Address _____ City _____ Zip Code _____

Cell Phone _____ Work Phone _____ E-mail Address _____

Occupation _____ Employer _____

How long with present employer _____ Highest Grade completed _____

Family History _____

Please list all persons living in the home (including grandparents, aunts, etc) and other siblings not in home:

Name	Age	Relation to student	Present school and grade, or highest grade completed	If a sibling, are they in this home most or all the time?		Language(s) Spoken
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	

Has this child ever experienced any parental separations, moves, divorces, death of close family members, other traumatic experiences, or other major life changes? NO YES

- If yes, When (month/year(s))? _____
- How old was this child at the time? _____
- Please describe the circumstances. _____

If parents are separated or divorced, who has physical custody of this child? _____

- Is there a joint custody agreement between parents? NO YES
- How often does the other parent see this child? _____
- Which parent has educational decision making rights? _____

Please check the corresponding box if any close biological members of the family have a condition listed below. If yes, please indicate the person's relationship to the child in the blank box to the right.

check	List person	check	List person
<input type="checkbox"/>	Attention Deficit Hyperactivity Disorder	<input type="checkbox"/>	Autism
<input type="checkbox"/>	Learning Difficulties in School	<input type="checkbox"/>	Developmental Delays
<input type="checkbox"/>	Speech or Language Concerns	<input type="checkbox"/>	Anger Management Issues
<input type="checkbox"/>	Depression/Anxiety	<input type="checkbox"/>	Alcohol and/or Drug Abuse
<input type="checkbox"/>	Other Psychological Disorders	<input type="checkbox"/>	Other Disorders that impacted education

Please mark other agencies involved in your child's life.

- | | |
|---------------------------|-----------------------|
| Social Services | Contact Person: _____ |
| Centennial Mental Health | Contact Person: _____ |
| Eastern Colorado Services | Contact Person: _____ |
| Children's Hospital | Contact Person: _____ |
| Other | Contact Person: _____ |

Please List all past/current treatment interventions (speech-language, psychology, ABA Therapy, occupational therapy, physical therapy, etc) for this child. _____

Child Care/Educational History _____

If primary caregivers work outside the home, please answer the following two questions.

How many hours per day is this child in a child-care setting? _____

How many different people care for this child? _____ Please explain _____

Schools (List schools attended, including preschool)

<u>Name</u>	<u>Location</u>	<u>Grade(s) Attended</u>	<u>Hours per day</u>	<u>Language of Instruction</u>

School Comments:

My child has:

Received extra support for _____ Dates _____ Repeated which Grade _____

Suspended for: _____ Grade(s) _____ Expelled for: _____ Grade(s) _____

Does your child excel at certain academic skill areas? _____ If yes, explain which areas. _____

What are your concerns about your child's school performance (homework, reading, spelling, math)? _____

When did these concerns begin? _____

Does your child have good attendance? _____ If not, are the absences health related or motivation concerns? _____

Social Relationships

How does your child get along with brother (s) and/or sister (s)? _____

How does your child get along with parents? teachers? other adults? _____

Fights frequently with playmates/peers NO YES

Prefers playing with younger children NO YES

Has difficulty making friends NO YES

Prefers to play alone or be alone NO YES

What role does this child take in peer group games or social interactions (for example, passive, leader, follower, aggressor, etc.)? _____

Social Emotional Behavioral Concerns _____

Do any of these behaviors describe your child? If yes, please check and describe if prompted.

Frequently refuses to obey

Lacks self-control

Laughs or cries at people or situations when not appropriate

Requires a lot of attention from parents or adults

Often aggressive towards objects or persons

Has excessive temper tantrums, If yes, please describe _____

Is impulsive, does things without thinking it through

On the go all of the time

When excited has a hard time calming down

Doesn't pay attention well for their age

Has difficulty starting a task or shifting between tasks

Has difficulty stopping when told to

Has difficulty transitioning (i.e. summer break to school, home to shopping, etc.)

If yes, please describe _____

Has difficulty recognizing other people's emotions (i.e. smiles means happy)

Has particular or unusual habits that you are concerned about

Seems to have repetitive actions

Is sensitive to sounds, taste, or touch? If yes, please describe _____

Cannot stop thinking/talking about certain topics

Shows excessive fear and anxiety If yes, please describe _____

Seems unhappy most of the time

Cries suddenly or frequently

Withholds affection

Speech and/or Language Concerns

Do you have concerns about your child's speech? NO YES

Did your child acquire language before the age of 3? NO YES

How well do others understand your child? _____

Do you often have to explain to others what your child is saying? If so, how? _____

Does your child use sentences that make sense? NO YES

Does your child answer simple questions? NO YES

Does your child make eye contact with you and others? NO YES

Does your child enjoy making family members laugh (makes silly faces or noises)? NO YES

Is your child frequently exposed to more than one language? NO YES

- If Yes, what language (s) _____
- Which language did they learn first (primary)? _____
- What age were they when exposed to the second language _____
- What language(s) does your child use with family? _____
- Language used with friends? _____

Early Childhood Adaptive/Developmental Milestones

Extremely fussy and temperamental as a baby NO YES

Diagnosed with failure to thrive? NO YES

Had irregular sleeping habits (woke often: talked in sleep) NO YES

Did new or infrequent situations lead to temper tantrums (holidays, visits to relatives, unusual feeding times) NO YES

Rocked and banged the crib? NO YES

Had excessive difficulties separating from parents after 3? NO YES

Check next to the skill if your child showed the skill within the normal developmental timeline.

	Rolled over		Sit up independently		Crawl
	Walk alone		Walk up and down stairs		Toilet Trained
	Fed self		Dress self		Groom self
	Understands yes and no		Said "mama" "dada" with meaning		Speak in sentences -4 words or more
	Apologizes		seeks out others to play		Plays with others
	Counts		flip through/read books		uses a pencil

Were there any losses of these skills at any time? If yes, please explain. _____

Medical History _____

Family Medical History

Please mark yes or no if any biological members of the family have any of the conditions listed below. If yes, please indicate the person's relationship to the child.

Yes	No	Medical Condition	Relationship	Yes	No	Medical Condition	Relationship
		Cancer				Diabetes	
		Heart Disease				High Blood Pressure	
		Kidney Disease				Migraine Headaches	
		Bleeding Disorders				Muscular Dystrophy	
		Tourette's Syndrome				Genetic Disorder	
		Seizures / Epilepsy				Other:	

Pregnancy

Did Mother of the Child obtain prenatal care? Yes No

 If so, when? Beginning Middle End

Were there any medical problems experienced during this pregnancy? Yes No

 if yes, please explain _____

Did Mother use any marijuana or alcohol before or during pregnancy? Yes No

 If yes, please explain: _____

Did Mother use any drugs (prescription or non prescription) before or during pregnancy? Yes No

How long was the pregnancy in weeks? _____ weeks

Birth

How was the child delivered? (Check one:)

 Normal Vaginal Birth Scheduled Cesarean Section Emergency Cesarean Section

What was the Birth weight: _____ lbs _____ oz

	Yes	No	
Were there any problems during delivery?			Explain:
Was your child Jaundiced (yellow-coloring of skin)?			Explain:
Did your child require Bilirubin lights?			For how long?
Did your child have any breathing problems?			Explain:
Did your child require supplemental oxygen?			For how long?
Did your child have a newborn hearing screening?			Results:

Current Medical Status

Is your child covered by:

 Medicaid Child Health Plan Plus (CHP+) Private Insurance No Health Insurance

In the past year my child's health has been: Great Good Fair Poor

How many school days has your child missed due to illness in the past year: _____

	Yes	No	
Does your child receive regular medical checks?			Child's family Physician:
Has your child had any significant accidents or injuries?			Explain:
Has your child been diagnosed with any medical problem?			Explain:

(Examples: Asthma, Diabetes, Seizures, etc)

	Yes	No	
Has your child been diagnosed with any psychological conditions? (Examples: Anxiety, Depression, ADHD, etc)			Explain
Has your child had any serious illnesses, hospitalizations or surgeries?			Explain:
Does your child receive dental care?			Child's Dentist:
Do you have any dental concerns for your child?			Explain:
Has your child ever been diagnosed as being underweight?			Explain:
Has your child ever been diagnosed as being overweight?			Explain:
Is your child allergic to any medications?			Explain and describe reaction:
Is your child allergic to any foods?			Explain and describe reaction:
Does your child require the use of Benadryl or Epinephrine for any allergies?			Explain and describe reaction:
Does your child receive routine eye examinations?			Eye Physician:
Does your child have any past or present eye problems?			Explain:
Does your child wear contacts or glasses?			Date of most recent Exam:
Is there anyone in the family with a hearing loss? (not from aging)			Explain:
Has your child ever been diagnosed with a hearing problem?			Explain:
Do you have any hearing concerns for your child?			Explain:
Does your child have ear infections? Did they have ear infections as a child?			Age of first? How many per year?
Did your child require ear tube placement?			When were they inserted? Did they have to be replaced?
Has your child ever had a hearing test or evaluation?			When? With Whom? Results?
Is your child currently on any routine medications?			Who is the prescribing doctor?

Please list and answer the following about the medications:

Medication	Dose	Times given?	Why prescribed?	When started taking it?	Improvement since taking?	Noticed side effects?

Thank you very much for the time and effort in completing this form!

Signature of person completing this form

Date