

## PARENT QUESTIONNAIRE FOR INDIVIDUALS 5 – 14 YEARS

Please complete the following questionnaire giving as much information as you can.  
Tick or circle all responses where appropriate.

### FAMILY DETAILS

Child's Name:	Date of Birth:
Parents' Names:	Child's Age:
Home Address:	Telephone Numbers: Home- Work- Mother- Father-
Email:	Fax No:
Brothers/Sisters and ages: ▪ ▪ ▪ ▪	List of people living at home: ▪ ▪ ▪ ▪
Is your child adopted?    Yes <input type="checkbox"/> No <input type="checkbox"/>	Is your child aware of this?    Yes <input type="checkbox"/> No <input type="checkbox"/>
If so, at what age?	
What is the main language spoken at home by... Father: Mother: To the child:	
General Practitioner's Name: Address:	
Telephone No:	

**CONCERNS AND EXPECTATIONS**

**Briefly list the main concerns about your child:**


**What do you consider are your child's strengths?**


**What would you like to gain from visiting the Assessment Service e.g. diagnosis, practical help?**


## PREGNANCY/BIRTH HISTORY

<b>Did you experience.....</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
An uneventful (normal) pregnancy		<input type="checkbox"/>	<input type="checkbox"/>	Excessive sickness during pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties during pregnancy		<input type="checkbox"/>	<input type="checkbox"/>	Did this continue throughout the pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what?				Describe if appropriate.		
<b>Was your labour.....</b>						
Normal		<input type="checkbox"/>				
Forceps		<input type="checkbox"/>				
Caesarean Section		<input type="checkbox"/>				
Premature		<input type="checkbox"/>	If so, how much?			
Late		<input type="checkbox"/>	If so, how much?			
<b>Any post natal problems?.....</b>						
Post natal depression		<input type="checkbox"/>	<input type="checkbox"/>			
Were there any difficulties in the first month after birth?		<input type="checkbox"/>	<input type="checkbox"/>	If so, what?		

## DEVELOPMENTAL HISTORY

<b>At what age did your child..?</b>	
<ul style="list-style-type: none"><li>• Sit unsupported:</li><li>• Crawl: (If not, did s/he 'bottom hotch' or 'commando crawl'?)</li><li>• Walk:</li><li>• Talk:</li></ul>	
<b>At what age was your child toilet trained?</b>	
<ul style="list-style-type: none"><li>• By day:</li><li>• By night:</li><li>• Any current problems?</li></ul>	
<b>Did your child have any feeding difficulties?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
If so, please describe:	
<b>In which hand does your child hold a pencil?</b>	Left handed <input type="checkbox"/> Right handed <input type="checkbox"/>
<b>Which foot does your child kick a ball?</b>	Left footed <input type="checkbox"/> Right footed <input type="checkbox"/>

**MEDICAL HISTORY**

	<b>Has your child ever had... If yes please give details</b>	<b>Have any family members (i.e. siblings, parents, grandparents etc.) had...? If yes please state who.</b>
Eczema	Yes/No	
Asthma	Yes/no	
Hayfever	Yes/No	
Epilepsy/ Convulsions/ Fits	Yes/No	
Speech and language difficulties	Yes/No	
Developmental difficulties such as dyslexia, dyspraxia, ADHD, Asperger's Syndrome etc.	Yes/No	
Mental Health problems	Yes/No	
Squints/Turns	Yes/No	
Headaches/Migraines	Yes/no	
Other (please state):		

**Has your Child had....?**

A hearing test	Yes/ No	Date:	Outcome:
A sight test	Yes/No	Date:	Outcome:
Does your child wear glasses?	Yes/ No	If so, what for?	

**Has your child had....?**

A serious injury	Yes/ No	If yes please describe:
A serious illness	Yes/No	If yes please describe:
Surgery	Yes/No	If yes please describe:
Bowel Problems	Yes/No	If yes please describe:
History of glue ear	Yes/No	If yes please describe:
Difficulty Sleeping	Yes/No	If yes please describe:
History of head Injury	Yes/No	If yes please describe:
Current medication	Yes/No	If yes please describe:
Any other treatments	Yes/No	If yes please describe:

**Has your child had an assessment or treatment with any health or education professionals such as..?**

	Dates(s)	Outcome	Was it helpful?
Occupational therapist			
Physiotherapist			
Speech & Language Therapist			
Educational Psychologist			

Paediatrician			
Behavioural Optometrist			
Dietician			
Teacher			
Complementary Therapist			
Other (please state)			

**EDUCATIONAL HISTORY**

Name of School:	
Address:	Telephone: Fax: E mail:
Teacher:	Principal:
<b>Please specify any additional assistance your child receives in class:</b>	
Assistance:	
Provided by:	
Frequency: (e.g. once a week).	Duration:
Has your child been away from school for any length of time? Please give details:	
Are you aware of any other problem areas in school? If so, please describe:	

**LISTENING AND COMMUNICATION SKILLS**

Does your child .....	Yes	No		Yes	No
Seem oversensitive to sound	<input type="checkbox"/>	<input type="checkbox"/>	Have hesitant speech/ stammer/ stutter?	<input type="checkbox"/>	<input type="checkbox"/>
Misinterpret simple questions/instructions	<input type="checkbox"/>	<input type="checkbox"/>	Appear to listen but not understand?	<input type="checkbox"/>	<input type="checkbox"/>
Get confused by similar sounding words	<input type="checkbox"/>	<input type="checkbox"/>	Have difficulty with speech sounds	<input type="checkbox"/>	<input type="checkbox"/>
Use gesturing only to make themselves understood	<input type="checkbox"/>	<input type="checkbox"/>	Misunderstand other gestures and facial expressions	<input type="checkbox"/>	<input type="checkbox"/>
Find it difficult to express thoughts verbally?	<input type="checkbox"/>	<input type="checkbox"/>			

**SOCIAL AND EMOTIONAL DEVELOPMENT**

Which would you say describes your child? (tick as many as appropriate)		
Quiet/ Withdrawn <input type="checkbox"/>	Aggressive <input type="checkbox"/>	Anxious <input type="checkbox"/>
Overactive/ Fidgety <input type="checkbox"/>	Craving attention <input type="checkbox"/>	Easily distracted <input type="checkbox"/>
Upset by failure <input type="checkbox"/>	Shy <input type="checkbox"/>	Temper tantrums <input type="checkbox"/>
Impulsive/no fear of Danger? <input type="checkbox"/>	Behavioural problems at day care facility? <input type="checkbox"/>	Having trouble understanding jokes? <input type="checkbox"/>
Having difficulty staying on task? <input type="checkbox"/>	Having frequent temper tantrums? <input type="checkbox"/>	Having regular 'tics' such as sniffing, facial grimacing or grunting? <input type="checkbox"/>
Having behavioural problems at home? <input type="checkbox"/>	Having trouble making/maintaining friendships? <input type="checkbox"/>	
Does your child prefer to play with children: Older <input type="checkbox"/> Younger <input type="checkbox"/> Same age <input type="checkbox"/>		
Does your child have a good relationship with his/her siblings?		Yes/ No
Does your child belong to any after school groups? If yes, what?		Yes/ No

**SENSORY MOTOR BEHAVIOUR**

Does your child.....	Yes	No		Ye	No
				s	
Dislike certain food textures?	<input type="checkbox"/>	<input type="checkbox"/>	Crave hugs and cuddles	<input type="checkbox"/>	<input type="checkbox"/>
Appear fearful of climbing such as on playground equipment?	<input type="checkbox"/>	<input type="checkbox"/>	Seeks out spinning or swinging activities?	<input type="checkbox"/>	<input type="checkbox"/>
Get car sick easily?	<input type="checkbox"/>	<input type="checkbox"/>	Have an excessive need to touch things?	<input type="checkbox"/>	<input type="checkbox"/>
Have extreme like / dislike of anything?	<input type="checkbox"/>	<input type="checkbox"/>	Get irritated by certain textures?	<input type="checkbox"/>	<input type="checkbox"/>
If yes please describe:					
Appear fearful of balance or climbing	<input type="checkbox"/>	<input type="checkbox"/>	Tire excessively?	<input type="checkbox"/>	<input type="checkbox"/>
Crave spinning or swinging	<input type="checkbox"/>	<input type="checkbox"/>	Get agitated by close proximity to other people?	<input type="checkbox"/>	<input type="checkbox"/>
Have extreme dislike of anything?	<input type="checkbox"/>	<input type="checkbox"/>	Reluctant to participate in sport?	<input type="checkbox"/>	<input type="checkbox"/>
Please describe:					

**CO-ORDINATION & SELF HELP SKILLS**

Does your child have difficulties with....	Yes	No		Yes	No
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	Standing on one leg	<input type="checkbox"/>	<input type="checkbox"/>
Undressing	<input type="checkbox"/>	<input type="checkbox"/>	Hopping	<input type="checkbox"/>	<input type="checkbox"/>
Tying shoe laces	<input type="checkbox"/>	<input type="checkbox"/>	Jumping	<input type="checkbox"/>	<input type="checkbox"/>
Fastening buttons	<input type="checkbox"/>	<input type="checkbox"/>	Skipping	<input type="checkbox"/>	<input type="checkbox"/>
Managing cutlery	<input type="checkbox"/>	<input type="checkbox"/>	Riding a bike	<input type="checkbox"/>	<input type="checkbox"/>
Managing personal toilet appropriately	<input type="checkbox"/>	<input type="checkbox"/>	Using playground equipment	<input type="checkbox"/>	<input type="checkbox"/>
Pencil tasks	<input type="checkbox"/>	<input type="checkbox"/>	Managing personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>
Using scissors	<input type="checkbox"/>	<input type="checkbox"/>	Walking on walls	<input type="checkbox"/>	<input type="checkbox"/>
Dislike playing with puzzles	<input type="checkbox"/>	<input type="checkbox"/>	Walking downstairs	<input type="checkbox"/>	<input type="checkbox"/>
Dislike playing with construction toys	<input type="checkbox"/>	<input type="checkbox"/>			

**VISUAL SKILLS**

Does your child.....					
	Yes	No		Yes	No
Seem to scan but not understand what s/he has read	<input type="checkbox"/>	<input type="checkbox"/>	Fail to recognise known words	<input type="checkbox"/>	<input type="checkbox"/>
Need to use a finger to follow print	<input type="checkbox"/>	<input type="checkbox"/>	Read better from flash cards than a book	<input type="checkbox"/>	<input type="checkbox"/>
Have difficulty colouring in	<input type="checkbox"/>	<input type="checkbox"/>	Have poor letter formation	<input type="checkbox"/>	<input type="checkbox"/>
Follow with head movements when reading	<input type="checkbox"/>	<input type="checkbox"/>	Have inadequate spacing	<input type="checkbox"/>	<input type="checkbox"/>
Have difficulty copying from the board	<input type="checkbox"/>	<input type="checkbox"/>	Have excessive spacing	<input type="checkbox"/>	<input type="checkbox"/>
Lose his/her place on the page frequently	<input type="checkbox"/>	<input type="checkbox"/>	Seem to write off the line	<input type="checkbox"/>	<input type="checkbox"/>
Blink/squint	<input type="checkbox"/>	<input type="checkbox"/>	Turn or tilt his or her head	<input type="checkbox"/>	<input type="checkbox"/>
Have one eye turning in/out	<input type="checkbox"/>	<input type="checkbox"/>	Close/cover one eye	<input type="checkbox"/>	<input type="checkbox"/>

**HISTORICAL OVERVIEW**

To conclude, could you on a separate sheet, give a concise overview of what has happened in the past including assessment and treatment received to date. Please also tell us something about your child's likes and dislikes.

***BEFORE RETURNING YOUR INFORMATION TO US, PLEASE ENSURE YOU HAVE READ AND UNDERSTOOD THE TERMS AND CONDITIONS STATED IN THE INFORMATION PACK.***

<b><i>Also check you have enclosed:</i></b>	
The administration fee <input type="checkbox"/>	An Adolescent Questionnaire <input type="checkbox"/>
All relevant and background information <input type="checkbox"/>	A Teacher Questionnaire <input type="checkbox"/>
A photograph of your child for our records <input type="checkbox"/>	

Signed..... Name..... Date.....

**THANK YOU. PLEASE RETURN QUESTIONNAIRE TO:**  
 The National Learning Network, Assessment Service, Block A, Institute of  
 Technology, Blanchardstown, Blanchardstown Rd. North, Dublin 15.