

ADOLESCENT QUESTIONNAIRE

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

Name:	Date of Birth:
Home Address:	Telephone Numbers: Home-
	Work-
Email:	Mobile-

Why do you want to come to see us?

ABOUT YOURSELF

	Yes	No
Do you have a particular friend or group of friends?	<input type="checkbox"/>	<input type="checkbox"/>
How often do you and your friend(s) go out and what do you do?		
What sorts of things do you like doing?		
Are there any situations or things you avoid?	<input type="checkbox"/>	<input type="checkbox"/>
Do you cope in large groups of people?	<input type="checkbox"/>	<input type="checkbox"/>
Are you confident about going out on your own?	<input type="checkbox"/>	<input type="checkbox"/>
Can you use public transport by yourself?	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to use the telephone confidently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hobbies or a special interest? Please state what:		

Do you have any problems sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you get tired easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty managing your clothes e.g. doing up buttons or fastenings/getting things on the right way and in the correct order?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any difficulties with personal care such as cleaning your teeth, washing your hair, wiping your bottom?	<input type="checkbox"/>	<input type="checkbox"/>
Can you make yourself a simple snack and a drink?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any difficulties with...		
Telling the time?	<input type="checkbox"/>	<input type="checkbox"/>
Managing money?	<input type="checkbox"/>	<input type="checkbox"/>
Using timetables/calendars?	<input type="checkbox"/>	<input type="checkbox"/>
Being on time for appointments or events?	<input type="checkbox"/>	<input type="checkbox"/>
Doing things you have been asked to do?	<input type="checkbox"/>	<input type="checkbox"/>

SCHOOL

What three things do you find hardest to do in school?

1. _____

2. _____

3. _____

What are the best parts of school for you?

e.g. subjects you enjoy.

Have you ever/or are you being bullied?

Yes

No

Tell us what has happened/is happening.

	Yes	No
Do you find it difficult to take notes down quickly in class, especially if: Dictated by the teacher? Copied from the board?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Do you think your work is neat?	<input type="checkbox"/>	<input type="checkbox"/>
Can you get your work completed in the time allowed in lessons?	<input type="checkbox"/>	<input type="checkbox"/>
Can you organise what you want to say in your head and then get it down on paper?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find it easier to use a computer rather than writing to produce your work?	<input type="checkbox"/>	<input type="checkbox"/>
What is the subject you dislike the most and why?		
Are you able to lay your work out neatly e.g. for diagrams and drawings?	<input type="checkbox"/>	<input type="checkbox"/>
Would you say you are organised in school? If not why?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find it hard to remember your homework/ books/ PE kit?	<input type="checkbox"/>	<input type="checkbox"/>
Do you do your homework on time?	<input type="checkbox"/>	<input type="checkbox"/>
Do you join in team games?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel confident using tools and apparatus in subjects like science and technology? If not why?	<input type="checkbox"/>	<input type="checkbox"/>

Signed

Date

THANK YOU. PLEASE RETURN TO:

National Learning Network Assessment Service, Block A, Institute of Technology, Blanchardstown,
Blanchardstown Rd. North, Dublin 15.