De LaSalle Academy

OF FORT MYERS

Parent/Guardian Questionnaire

Directions: Thank you for taking the time to answer these questions. Please return the form to De LaSalle Academy by mail, fax, or by emailing sbarrow@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 Phone: _____

_____ Cell Phone : _____

Email: _____

What are your primary concerns for your child? □ Academic □ Social □ Behavioral

Please describe your primary concerns: _____

_____

_____

_____

Describe your child's strengths: _____

_____

_____

_____

_____

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

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

Please submit copies of all evaluations that have been completed in the last 3 years. If there have been none, please submit the most recent evaluation.

What diagnosis is indicated on 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 □ Speech □ OT □ PT □ Counseling □ ABA □ Other: _____

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Developmental Skills

Please check the response that best describes your child's current 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	☐	☐	☐	☐
Memorizing new content	☐	☐	☐	☐

School Performance

Please check the response that, in your view, best describes your child's current academic functioning.

Reading	Don't Know	Below Average	Average	Above Average
Reading Words	☐	☐	☐	☐
Comprehension	☐	☐	☐	☐
Speed (fluency and accuracy)	☐	☐	☐	☐
Spelling	☐	☐	☐	☐
Math				
Calculation (can add, subtract, etc.)	☐	☐	☐	☐
Applications (e.g. word problems)	☐	☐	☐	☐
Remembers math facts easily	☐	☐	☐	☐
Writing				
Content (ability to communicate ideas)	☐	☐	☐	☐
Mechanics (grammar/punctuation)	☐	☐	☐	☐
Neatness (including letter formation)	☐	☐	☐	☐

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

Organization/Study Habits	Never/ 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	☐	☐	☐	☐

When is homework usually done?

- □ As soon as s/he comes home from school
- □ Before dinner
- □ In the morning
- □ After school program
- □ After dinner
- □ No 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 share any additional information that would help school personnel understand your child's academic needs:

_____

_____

_____

_____

Behavior Inventory

Please check the responses that best describe your child's behavior patterns.

Attention	**Never**	**Just a Little**	**Often**	**Almost Always**
Does not pay close attention to detail, makes careless mistakes	□	□	□	□
Has difficulty maintaining attention for long periods of time	□	□	□	□
Has difficulty following instructions	□	□	□	□
Does not finish what is started (i.e. schoolwork or chores), not due to refusal or failure to understand instructions	□	□	□	□
Seems unorganized	□	□	□	□
Reluctant to engage in challenging tasks requiring prolonged mental effort	□	□	□	□
Loses things necessary for tasks and/or activities	□	□	□	□
Distractible				
Forgetful	□	□	□	□
Appears not to listen	□	□	□	□
Activity				
Fidgets or squirms in seat	□	□	□	□
Leaves seat when remaining seated is expected				
Runs about or climbs excessively at inappropriate times	□	□	□	□
Has difficulty playing quietly	□	□	□	□
Is "on the go" or acts as if "driven by motor"	□	□	□	□
Talks a lot	□	□	□	□
Impulsivity				
Blurts out answers or questions	□	□	□	□
Has difficulty awaiting his/her turn	□	□	□	□
Does things without considering consequences	□	□	□	□
Interrupts or intrudes on others (discussions, games, etc.)	□	□	□	□
Opposition				
Loses temper	□	□	□	□
Argues with adults	□	□	□	□

	Never	Just a Little	Often	Almost Always
Refuses to obey rules or commands	☐	☐	☐	☐
Deliberately annoys people	☐	☐	☐	☐
Blames others for his/her mistakes or misbehavior	☐	☐	☐	☐
Is touchy or easily annoyed by others	☐	☐	☐	☐
Seems angry/resentful	☐	☐	☐	☐
Spiteful or wants revenge	☐	☐	☐	☐
Somatic				
Seems sad, unhappy, or depressed	☐	☐	☐	☐
Cries or whines easily	☐	☐	☐	☐
Seems nervous or irritable	☐	☐	☐	☐
Facial tics or twitches	☐	☐	☐	☐
Decreased appetite	☐	☐	☐	☐
Drowsy or sleeping during the day	☐	☐	☐	☐
Seems anxious or worried	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Stomachaches	☐	☐	☐	☐
Peer Interaction Skills				
Has a best friend	☐	☐	☐	☐
Makes friends easily	☐	☐	☐	☐
Keeps friends	☐	☐	☐	☐
Shows good sportsmanship	☐	☐	☐	☐
Is bossy/needs to be in control	☐	☐	☐	☐
Is physically aggressive with peers	☐	☐	☐	☐
Prefers to play alone	☐	☐	☐	☐
Gets teased	☐	☐	☐	☐
Teases others	☐	☐	☐	☐
Prefers peers who are:				
Same age	☐	☐	☐	☐
Older	☐	☐	☐	☐
Younger	☐	☐	☐	☐
Opposite Sex	☐	☐	☐	☐

Please indicate whether your child presents any problems with compliance to instructions, commands, or rules in the following situations by circling the "yes" or "no" response space. If you answer "yes", circle the number that most appropriately indicates the severity of the problem.

Situation			**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	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

Does your child have:

- ☐ Trouble getting into bed
- ☐ Trouble staying asleep
- ☐ Trouble falling asleep
- ☐ None of these

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

Health History

Has/does your child had/have any of the following health conditions?

	No	Yes		No	Yes
Asthma	☐	☐	Heart problems	☐	☐
Chronic ear infections	☐	☐	Seizures	☐	☐
Vision problems	☐	☐	Chronic sinusitis	☐	☐
Hearing problems	☐	☐	Incontinence	☐	☐
Head trauma w/ loss of consciousness	☐	☐	Loss of consciousness w/out head trauma	☐	☐
Other _____	☐	☐		☐	☐

Has your child ever been hospitalized? □ No □ Yes

If yes, list reason and age of child at the time of hospitalization: _____

Has your child undergone surgery? □ No □ Yes

If yes, list surgery and age of child at the time of surgery: _____

Is your child allergic to any medications, foods, plants, etc? □ No □ Yes

If yes, please list all: _____

Does your child have any physical limitations that the school staff should be aware of? □ No □ Yes

If yes, please list all: _____

Is your child currently taking any prescription or over the counter medications? □ No □ Yes

If yes, please list all:

Name: _____ Dose: _____ Reason: _____

Name: _____ Dose: _____ Reason: _____

Name: _____ Dose: _____ Reason: _____

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

Name	Type of Provider

Home Environment

Marital status of Parents/Guardians				Child's Siblings			
	No	Yes	How Long?	Name	Age	M/F	Lives w/ Child
Married	□	□					□
Divorced	□	□					□
Separated	□	□					□
Mother Remarried	□	□					□
Father Remarried	□	□					□

Who lives with this child?
□ Mother □ Father □ Step-mother □ Step-father □ Siblings □ Grandparent(s) □ Other _____

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.

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Thank you for taking the time to complete this questionnaire.