PRE-SERVICE QUESTIONNAIRE

NOTE TO PARENT OR GUARDIAN: PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE. USE THE BACK OF EACH SHEET FOR MORE SPACE. YOUR ANSWERS WILL HELP US TO SERVE THE STUDENT MORE EFFECTIVELY. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

A. GENERAL INFORMATION

Student's Name: _____ Sex: M__ F__

Home Address: _____

Home Telephone: _____ Cell:_____

Date of Birth: _____ Age:_____

School: _____ Grade: _____

Referred By: _____

Name of Person Completing this Form:_____

Relationship to Student: _____

B. STATEMENT OF ISSUES

What do you feel are the student's issues at school?

_____

What are the issues at home?

_____

_____

Who noticed the first issue(s) and when?

_____

_____

What do you feel has caused this issue(s) to occur?

_____

In what way is the student aware of / sensitive about his/her issues?

_____

_____

Has the student ever been tested? YES / NO

Has he/she received help for this issue? _____ . If yes, please give dates, school, agency/professional(s) that provided services:

Type of Service	School/Agency	Dates

C. FAMILY FACTORS

Mother's Name: _____Marital Status: _____

Address:_____

Occupation: _____

Home phone: _____ Cell: _____

Last Schooling Completed: _____

Any history of special needs? _____

Father's Name: _____ Marital Status: _____

Address: _____

Occupation: _____

Home Phone: _____ Cell: _____

Last Schooling Completed: _____

Any history of special needs? _____

Please list other members of student's household:

_____

Have any members of your family experienced learning challenges ?

_____

Main Language spoken at home: _____

Other Languages? _____

D. SCHOOL HISTORY

List in order the schools the student has attended

School	City	Dates	Grades	Reason for Leaving

E. DEVELOPMENTAL HISTORY

PREGNANCY

How would you describe your pregnancy?
_____

Did you experience any illnesses, accidents, shocks, mental or physical strain, or any other complications? If yes, explain briefly:
_____

_____

Did you take any medications? _____ _____

Was the student's birth normal? (full-term, natural) _____
_____

EARLY YEARS AND OVERALL HEALTH

Describe your child's early development (general health, accidents, ear-infections, sleep habits, eating….)
_____

_____

_____

_____

Were there any instances of high fevers, convulsions, head injuries, or loss of consciousness? _____
Was your child on any medications? Is he/she on any now? If so, for how long?
_____

_____

_____

How much sleep does the student get each night? _____
Does he/she have difficulty sleeping? _____

Describe his/her appetite:

_____

_
_____

Any food allergies? _____

How would you describe the student's overall health?
_____

Does the student have any co-ordination problems? Explain.
_____

_____

Date of most recent physical:_____
Eye exam:_____
Hearing exam:_____

DEVELOPMENTAL MILESTONES

At what age did he/she master these skills? Be as specific as possible, or put a ? next to your answer.

Babbled _____ said single words _____
2-3 word combinations _____ read _____

Early Literacy Development

What language does he/she speak at home most of the time?
_____

Does anyone read to him/her on a regular basis?
_____

Does he/she have any favorite storybooks?
_____

Did he/she ever pretend to read to you or a toy?
_____

Did he/she try to write before entering school?
_____

How much TV does he/she watch on a daily basis? What shows?
_____

_____

SOCIAL/EMOTIONAL BEHAVIORS

What happens when he/she encounters a conflict with a person or situation?

_____

_____

_____

_____

Has the student ever had emotional or behavioral problems? If yes, describe.

_____

_____

_____

Have you sought professional help for this issue?

_____

Please place a check mark in front of behaviors that seem to describe him/her to some degree. The behavior should occur at least 2-3 times a week.

	Behaviors		**Behaviors**
	Restless		Argumentative
	Shy, withdrawn		Cheerful
	Fearful		Talkative
	Confident		Picky eater
	Physically active		Easily frustrated
	Clumsy		Forgetful
	Sleeps poorly		Fidgety
	Short attention span		Plays well with others
	Poor sense of direction		Hoards
	Angry		Poor sense of time
	Resists doing homework		Expresses self well verbally
	Loses objects		Leaves projects incomplete
	Has difficulty concentrating		Disorganized
	Does not follow directions		Nervous
	Creative		Inconsistent

Check any of the following experiences that your child is regularly exposed to (at least once or twice a year) or frequently engages in:

	Music lessons		Organized sports
	Dance class		Swim class
	Movies		Video-games
	Arcade games		Family hobbies
	Independent reading		Reading aloud
	TV viewing		Being read to
	Museum visits		Theater
	Day Camp		Overnight Camp
	Overnight camp in group		Extended vacation
	Board games		Pet care

Any other play / activities / hobbies?

_____

Describe any nervous habits /tics the student has or had:

_____

_____

Describe any fears the student has or had:

_____

_____

Is your child easy, fairly easy, or hard to manage?

_____

Describe the most common method(s) of discipline used.

_____

_____

_____

Which present behavior do you wish to change first?

_____

PERSONAL CHARACTERISTICS

Does he/she enjoy reading? _____
Does he/she like school?_____
Any favorite subjects?_____
What subject is liked least?_____
Did he/she attend pre-school?_____
About how many days a year does he/she miss school?_____

Thank you!