



Providing children and their families with quality diagnostic and educational services

PARENT QUESTIONNAIRE

Name of child: _____

Birth date: _____

Home address: _____

Home phone: _____

Parents: _____

Educational level: _____

Occupation: _____

Place of Employment _____

Who referred you to Learning Curve? _____

What would you most like to learn from this evaluation?

BIRTH/DEVELOPMENTAL HISTORY

PREGNANCY:

Was your child adopted? yes ___ no ___

If yes, at what age: ___

Please describe any birth or delivery complications:

Birth Weight ___ lbs. ___ oz.

DEVELOPMENTAL MILESTONES

1. Do you recall any delays in the following areas? If yes, please describe:

Gross Motor Skills (sitting, crawling, walking) yes ___ no ___

Fine Motor Skills (cutting with scissors, tying shoes) yes ___ no ___

Language Skills (first words, talking in sentences) yes ___ no ___

2. Does your child have any speech or language problems?

yes ___ no ___

If yes, please describe: _____

MEDICAL HISTORY

Name of Pediatrician _____

1. Does your child have a history of any of the following:

Chronic ear infections yes ___ no ___

Seizures yes ___ no ___

Tics/Twitches yes ___ no ___

Sleep Problems yes ___ no ___

Attention Problems yes ___ no ___

Emotional/Behavioral Problems yes ___ no ___

Sensory Issues yes ___ no ___

2. Is your child currently taking any medications? yes ___ no ___

If yes, please describe:

3. Has your child ever been hospitalized? yes _____ no _____
If yes, please specify the reason, as well as your child's age:

FAMILY MEDICAL HISTORY

1. Is there a family history (relatives, siblings, parents) of medical or learning problems, including emotional or behavioral problems no _____ yes: Please describe:

SOCIAL AND BEHAVIORAL HISTORY

1. Who lives with your child (parents, siblings, others; ages)?

2. What are your child's interests/hobbies?

3. How would you describe your child's personality? _____

4. If applicable, how does your child get along with his/her siblings?

5. How does your child get along with peers?

6. Has your child received any psychological or psychiatric treatment?
yes____ no____

7. If yes, please complete below:

Provider	Reason	Dates

EDUCATIONAL HISTORY

1. At what age did your child begin school? _____

2. What grade is your child currently in? _____

3. What school does your child currently attend? _____

School Address: _____

4. What is(are) the name of your child's teacher(s)? _____
special educator(s)? _____

5. Please list all schools your child has attended:

Grade(s)	Name of School	Years Attended

6. If your child has had any difficulties in school (academic or behavioral),
in which grade did these problems start? _____

7. Does your child like school? yes____ no____

8. Briefly describe your child's school experiences with regard to academic performance:

9. What kinds of grades does your child typically earn? _____

10. Has your child been tested before for academic, learning or behavioral issues?

yes ___ no ___ If yes, please complete the following section:

Evaluator	Place of Evaluation	Date	Conclusions

11. Please use this area to share any additional information which you feel is important regarding your child:

PLEASE ENCLOSE ANY PREVIOUS REPORTS TO MAXIMIZE THE BENEFITS OF THIS EVALUATION AND TO ASSURE THAT THE SAME TESTS ARE NOT GIVEN TWICE, POSSIBLY INVALIDATING RESULTS.

Thank you for completing this form. We look forward to meeting with you and your child.

Form Completed by: _____ Date: _____
Relationship to Child: _____