



# Spring Valley Testing Center Parent Questionnaire

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## Dear Parents:

Your completion of this form will greatly help in understanding your child, adolescent, or young adult (referred to as "client" below). This information is confidential and will not be released without written permission from you; however, there are some exceptions to confidentiality, which are discussed in detail on the Information Sheet. This data is useful in understanding the questions to be answered by the evaluation and may be referred to in the written report. If extra space is needed, please feel free to attach additional pages for your comments.

Date: \_\_\_\_\_

Person(s) filling out this form: \_\_\_\_\_ Father \_\_\_\_\_ Mother \_\_\_\_\_ Other \_\_\_\_\_

## Identification Data

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Date of Birth \_\_\_\_\_ School \_\_\_\_\_

Current Grade \_\_\_\_\_

Child lives with \_\_\_\_\_

At \_\_\_\_\_

(address, city, state, zip)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(area code & home phone)

(cell phone number)

(e-mail address)

\*In the case of custody agreements, single-parenthood, or legal guardianship being assumed by person(s) other than a biological parent, the SVS Testing Center is required to have documentation of the court-ordered custody agreement with submission of paperwork and deposit. Failure to provide this information will delay your appointment.

Referred by \_\_\_\_\_

List names, as appropriate:

Father \_\_\_\_\_

Stepfather \_\_\_\_\_

Mother \_\_\_\_\_

Stepmother \_\_\_\_\_

How often does the child visit the non-resident parent? \_\_\_\_\_

**Present Employment of Resident Parents/Guardians:**

Father (stepfather) \_\_\_\_\_ Business phone \_\_\_\_\_

Mother (stepmother) \_\_\_\_\_ Business phone \_\_\_\_\_

**Purpose of this Evaluation**

What questions would you like answered by this evaluation? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This child's strengths include \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I believe this child's main problem(s) to be \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The report intended for whom (e.g., present school, future school, physicians, etc.)?

\_\_\_\_\_

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## Child's Medical History

If the child has had any of the following, give age or the approximate age, if unsure.

Mumps \_\_\_\_\_ Measles \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Meningitis \_\_\_\_\_

Frequent headaches \_\_\_\_\_ Hearing problems \_\_\_\_\_ Stomach upsets \_\_\_\_\_

Frequent colds \_\_\_\_\_ Whooping Cough \_\_\_\_\_ Hay Fever \_\_\_\_\_

Sore throats \_\_\_\_\_ Cerebral Palsy \_\_\_\_\_ Ear infections \_\_\_\_\_

High fevers: Age \_\_\_\_\_ Cause \_\_\_\_\_ How High \_\_\_\_\_

For how long? \_\_\_\_\_

Allergies to \_\_\_\_\_

Comments \_\_\_\_\_

Please describe any other medical conditions \_\_\_\_\_

Describe any serious accidents this child has had \_\_\_\_\_

Age at time of accident \_\_\_\_\_ Actions taken \_\_\_\_\_

Treatment given \_\_\_\_\_

Hospitalizations (state age, duration, and reason) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This child was last seen by Dr. \_\_\_\_\_ Date \_\_\_\_\_

(Please print first and last names)

The physical examination revealed \_\_\_\_\_

\_\_\_\_\_

Is this child taking any medication? \_\_\_\_\_

Name of Medication	Dose	How Often?
Has child taken any other medications taken in the last twelve months?		

Has hearing been checked? \_\_\_\_\_ Date \_\_\_\_\_

If yes, where? \_\_\_\_\_ at school; \_\_\_\_\_ in doctor's office; \_\_\_\_\_ by an Audiologist

Results: \_\_\_\_\_

Has vision been checked? \_\_\_\_\_ Date \_\_\_\_\_

If yes, where? \_\_\_\_\_ at school; \_\_\_\_\_ By an ophthalmologist/optometrist

\_\_\_\_\_ By pediatrician/internist

Results: \_\_\_\_\_

\_\_\_\_\_

If inadequate, please explain: \_\_\_\_\_

Is this child on a special diet? \_\_\_\_\_ Restrictions \_\_\_\_\_

## Family History

Present health of immediate family members \_\_\_\_\_

Additional comments \_\_\_\_\_

List by names the members of this child's family. Please include parents, stepparents, full, half, and step-siblings.

Family Member Name	Relationship to Child	Age	Highest Year of School Completed	List Grade(s) Repeated	Any problems with Reading, Writing, Math, or Speech/Language? If yes, which, and what grade(s)?

## School History

List the names of schools attended, beginning with kindergarten:

School Name	Age of Child	Grade #s	City & State	Public or Private?

Was entry into first grade delayed by attending Kindergarten twice or a pre-first grade? \_\_\_\_\_

Was any grade repeated? \_\_\_\_\_ If yes, grade(s) \_\_\_\_\_

### Current School Data:

Present teacher(s) name(s) \_\_\_\_\_

The child's best subject(s) is/are \_\_\_\_\_

Grade history (general) \_\_\_\_\_

Please list your child's most recent grades \_\_\_\_\_

Does your child finish his/her work in class? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child have trouble paying attention? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child have trouble staying in his/her seat when asked? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child have difficulty working independently? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your child had (or is receiving) special help at school? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what type (e.g., tutoring, speech therapy, resource room) and when? Please describe.

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Homework: Done easily? \_\_\_\_\_ With difficulty? \_\_\_\_\_

Needs help with (describe) \_\_\_\_\_

Source of help: At home \_\_\_\_\_ At School \_\_\_\_\_

Studies: When \_\_\_\_\_ Where? \_\_\_\_\_

How long? \_\_\_\_\_ Puts off studying until last minute \_\_\_\_\_

Does your child like school? \_\_\_\_\_ Comments \_\_\_\_\_

What does the teacher think the problem is? \_\_\_\_\_

What does the teacher think about the child's behavior? (e.g., general attitude, response when corrected, relationship with classmates, etc.) \_\_\_\_\_

## Behavior

Circle your responses to the following:

This child:

- Eats (enough, too little, too much).
- (Accepts, hates, likes, resists) going to bed.
- Goes to bed (at a certain time, when he/she wants to), bedtime is
- (Frequently, occasionally, seldom, never) wets the bed.
- Seems to feel (good, tired, dizzy, sleepy) in the morning.

- (Walks, talks, cries, tosses) in sleep.
- Sleeps with a toy or plaything.
- Sleeps (by himself, with parents, with brother, with sister, or someone else).

**Nightmares:** Describe the child's nightmares, child's reaction and frequency of occurrence.

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**This child has had, or is still having problems with which of the following:**

	What Ages(s)	How Often
<b>Bullying:</b>	_____	_____
<b>Shyness:</b>	_____	_____
<b>Hair twisting</b>	_____	_____
<b>Thumb sucking</b>	_____	_____
<b>Nail biting</b>	_____	_____
<b>Finger sucking</b>	_____	_____
<b>Excessive demands</b>	_____	_____
<b>Fear of darkness</b>	_____	_____
<b>Restlessness</b>	_____	_____
<b>Daydreaming</b>	_____	_____
<b>Truancy</b>	_____	_____
<b>Fighting</b>	_____	_____

Temper tantrums	_____	_____
Resenting discipline	_____	_____
Always hungry	_____	_____
Bad dreams	_____	_____
Ignoring commands	_____	_____
Other (please describe)	_____	_____

Has this child ever had contact with the police or juvenile authorities? If so, please explain.

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Please describe any unusual behavior patterns your child possesses (positive or negative).

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This child is (easy, difficult) to manage. \_\_\_\_\_ Do parents agree? \_\_\_\_\_

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Does child have a pet? \_\_\_\_\_ Is If yes, what? \_\_\_\_\_

What responsibility does child assume for its care? \_\_\_\_\_

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Does this child have regular chores? \_\_\_\_\_ Specify \_\_\_\_\_

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This child (always, usually, seldom, never) remembers to do these chores.

What activities does the family do together? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe how this child gets along with:

Father \_\_\_\_\_

Mother \_\_\_\_\_

Brother(s) \_\_\_\_\_

Sister(s) \_\_\_\_\_

Step family member in home \_\_\_\_\_

Others in home \_\_\_\_\_

\_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

This child talks more freely with (mother, father, sister, brother, other: give relationship)

\_\_\_\_\_

This child seems to get most upset when \_\_\_\_\_

This child seems happiest when \_\_\_\_\_

### Recreation & Interests

This child has (many, average, few, no) friends. \_\_\_\_\_

Approximately how much television does this child watch per day? \_\_\_\_\_

\_\_\_\_\_

In recreational activities, this child most often prefers the company of others (younger, older, his/her own age). \_\_\_\_\_

If this child could, this child would like to have (many, few) friends; do things (alone, with just one friend, in a group). \_\_\_\_\_

This child likes best to associate with (boys, girls, both the same). \_\_\_\_\_

This child seems to enjoy most games that are (rough, noisy, quiet; require a great deal of make-believe; require little physical activity; have definite rules). \_\_\_\_\_

This child, when losing a game, usually (loses his/her temper, keeps right on playing, works even harder, seems to "give up," blames someone or something for the loss, gets discouraged and wants to quit). \_\_\_\_\_

This child likes best to socialize (at home, at someone else's house). \_\_\_\_\_

This child likes best to "make rules" and decide how things will go or have someone else make the decisions. \_\_\_\_\_

This child (likes, dislikes) close attention or supervision. \_\_\_\_\_

What does this child like to do for recreation? \_\_\_\_\_

This child takes part in which of the following activities outside of home or school:

Scouts \_\_\_\_\_ YMCA \_\_\_\_\_ Clubs \_\_\_\_\_ Youth Groups \_\_\_\_\_ Other \_\_\_\_\_

Please describe any unusual behavior (positive or negative) you have observed at these activities:

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What plans do you have for changes in such areas as family, school, social, medical, etc., which have not been mentioned elsewhere in this questionnaire?

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**Other Specialist(s) Consulted**

Name \_\_\_\_\_ Date \_\_\_\_\_

Agency \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Their findings/recommendations:

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Name \_\_\_\_\_ Date \_\_\_\_\_

Agency \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Their findings/recommendations: \_\_\_\_\_

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