

H.I.S. PLACE FOR HELP IN SCHOOL

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PARENT QUESTIONNAIRE

Child's Name _____ Date: _____

Parents' Name/s _____ Date of Birth _____ Age _____

Address _____ Grade in school _____

_____ How long home schooled? _____

City _____ State _____ ZIP _____ How many siblings? _____

Phone (H) _____ - _____ - _____ (W) _____ - _____ - _____ E-Mail _____

Name of present school. _____

If home schooled, what test is given at end of year? _____

Has your child been evaluated/tested for hearing problems? _____ Vision? _____ Had vision therapy? _____

Does child wear glasses? _____ hearing aid? _____

Has child ever been tested for **learning problems**? Y or N If YES, by whom? _____

List the given tests by name:

Please answer the following questions as fully as possible. Use the back of the sheet or extra pages if necessary.

1. General Health:

Y/N Were there complications in pregnancy? How many weeks old was child when delivered? _____

Y/N Was the child premature? Birth Weight _____

Y/N Was the baby hospitalized immediately after birth? *Please explain and tell how the problem resolved.*

Y/N Has your child had major illnesses, been hospitalized, or had major surgeries (ear tubes, hernia, etc.)

Y/N Is your child currently taking medications (Ritalin, other medicines)? *If YES, list and tell what each is for.*

Y/N Has your child ever experienced a serious head injury? *If YES, at what age?* _____

If yes, please **explain** what happened and how the child responded – became sleepy, became unconscious, had headaches afterwards? _____

What was the diagnosis? _____

****Optional** (If the answer below is “yes,” the information requested is very important to provide an accurate diagnosis – ALL answers will be kept highly confidential.)

Was your baby exposed to narcotic drugs, alcohol, or toxic substances while you were pregnant? _____

If YES, please explain: _____

2. Allergies:

Y / N Has your child been tested for allergies? If YES, when? _____ By Dr.: _____

Y / N Does your child take allergy shots on regular basis? How many? _____ How often? _____

Does your child have: [check all that apply]

Y / N frequent headaches

Y / N itchy skin

Y / N watery eyes

Y / N frequent runny nose

Y / N frequent earaches

Y / N seasonal symptoms

Y / N reactions to foods

Y / N reactions to chemicals/paints

**** Add other information about allergy problems that you believe are significant on the reverse side of this sheet.

3. Background Information:

Y / N Does anyone in your immediate family have a history of learning problems? Father ____ Mother ____

Explain: _____

Y / N Do any blood relatives or children in your immediate family have ADD/ADHD? What relation to the child?

Y / N Did you have to move a lot in recent years? If YES, how did your child adjust? _____

Y / N Has your child been in public school? If YES, which grade/s? _____

Y / N Been retained? If YES, in what grade? ____ Why? _____

Y / N Did the child's school ever tell you **not** to correct spelling mistakes on your child's writing?

Y / N Was your child taught to read using the Whole Language/Sight Word method? Or a phonics method? _____

What reading program did your child use when learning to read? _____

(If applicable) At what age did the child read? _____

What do you see as your child's greatest **weakness**? _____

What kind of schoolwork seems to frustrate your child the most? _____

Describe a typical difficult assignment and how the child responds to it.

What do you think is your child's greatest **strength**? _____

What works to help your child do better? _____

What are you doing to develop strengths for your child? _____

4. Attention:

- Y / N Does your child pay appropriate attention when you speak?
- Y / N Does your child seem to “zone out” when you talk with him/her, or when he/she is doing work?
- Y / N Does your child have trouble remembering what you say?
- Y / N Does your child have trouble following directions with more than one step, or forget items on a list of things to do, such as “Make your bed, pick up your socks, and put them in the laundry.”
- Y / N Does your child seem to make careless errors?
- Y / N Does he/she seem to rush through things or skip questions on worksheets or tests?
- Y / N Does your child seem accurate, but slow, on assignments?
- Y / N Work better when not timed?
- Y / N Does your child have difficulty carrying out a complex task or organizing information mentally?
- Y / N Does your child act impulsively - even to the point of putting him/herself in danger?
- Y / N Does your child have difficulty staying organized?
- Y / N Does your child have times of restlessness or excess physical activity at inappropriate times?

If YES, give an example of what the child was doing, where, and how it seemed inappropriate:

5. Development of Language:

- Y / N Did your child speak at typical age? at about what age? _____ talk in sentences? _____
- Y / N Did your child point rather than say what he/she wants after age two? *How long?* _____
- Y / N Does your child have specific speech difficulties? *If YES, give describe /give examples:*

Y / N Has anyone expressed concern to you about your child’s speech/language development?.

If YES, what are the concerns?

- Y / N Does your child have trouble explaining what's on his/her mind?
- Y / N Does your child have trouble communicating with other children?
- Y / N Is your child easily frustrated when you don't seem to understand? *Give an example:*

- Y / N Did your child have trouble waiting to take a turn?
- Y / N Does your child have trouble getting along with kids his/her age?
- Y / N Does your child forget test answers soon after they studied hard and seemed to know the answers?
- Y / N Does this happen more frequently in a particular subject area? *Which one?* _____
- Y / N Does your child have trouble coming up with the right word in talking spontaneously?
- Y / N Does your child have trouble coming up with the right word in answering questions?
- Y / N Does the child have trouble explaining the **meaning** of vocabulary words?

Describe the general environment where your child works and studies - daily classroom; with siblings or peers, etc.

Y / N Do you maintain a regular daily and/or weekly schedule? (e.g., regular support groups, YMCA, etc.)

Y / N Does your schedule vary frequently enough so certain subjects are often left out for days at a time?

Y / N Are there factors in the home teaching environment that might interfere with the child's present performance – such as recent loss of family member or pet, or a recent move? *Explain briefly:*

Y / N Does the child have access to a quiet place to study and work?

Y / N Does your child use or have access to a computer?

6. School Environment/Curriculum:

Describe the curriculum you use for each subject you teach your child.

(If you are uncertain, please check and send this information later by email to learn@helpinschool.net.)

Subject	Time per day or week	Books/Curriculum Used	Grade level of materials in use

7. Assessment/Testing:

Y / N Do you regularly test your child in academic subjects?

How is the child assessed/tested? Please check *all* that apply. Check TWICE if you use any method a **lot!**

- textbook or curriculum-provided tests
- oral parent-created tests
- written parent-created tests
- true/false tests
- multiple choice
- written composition
- informal – parent asking questions as parent and child work through the content
- oral testing
- written testing from textbook teacher manuals
- regularly scheduled evaluations – e.g., spelling tests each Friday?
- rubrics (scoring guides), *or* I don't know what a rubric is!

8. Home School Environment:

Y / N Are both parents instructing the child? *If YES, what does each parent teach?*

List all socializing or educational activities, outside the home school, in which the child participates regularly:

Y / N Does the child's learning problems cause any kind of difficulty in these extra activities?
(e.g., does the child have to memorize Bible verses, yet he or she cannot memorize?) *Give examples.*

Y / N Did the child ever have an IEP before you started home education? *If YES, please provide a copy.*

Y / N Does the child have a current IEP from the public schools? *If YES, please provide a copy.*

Y / N Does the child obtain any services from the public school – such as Occupational Therapy or Speech?

9. Reading:

Y / N Does the child have trouble remembering what was just read?

Y / N Does the child have trouble answering fact questions about what was just read? *In which subjects?*

Y / N Did your child have trouble learning the sounds that letters make? *Which ones?* _____

Y / N Were some letter sounds harder than others? *Give examples:* _____

Y / N Does the child frequently lose his/her place during reading aloud?

Y / N Does the child follow the words using a pointing finger?

Y / N Did the child avoid reading aloud altogether? *If YES, does he/she say why? Explain:*

Y / N Does the child have trouble leaving out words while reading aloud?

Y / N Is the child saying the words to himself under his breath as he reads?

Y / N Does the child reverse words? sounds within words?

Y / N Substitute a word with another word that starts with same letter as the one missed?

Y / N How does the child feel about reading overall? _____

Y / N Can your child rhyme one word with another?

Y / N Does your child have difficulty naming numbers, letters, or colors? *If YES, give examples:*

Y / N Can the child summarize a passage that was just read?

Y / N Does the child answer reading questions with irrelevant details instead of the main idea?

Y / N Does the child read very laboriously, word by word, with little expression?

Y / N Does he/she skip punctuation or read as if punctuation weren't there?

Y / N Is there any sign that the child cannot distinguish difference between sounds clearly? *If YES, explain:*

10. Spelling:

Y / N Is the child's spelling inconsistent from page to page, week to week?

Y / N Do the spelling errors seem related to the actual sounds of the letters missed?
*Example: **phone** misspelled as **fone**? Attach work samples if available.*

Y / N Do you notice frequent spelling reversals of letters or other patterns of errors?

Y / N Does your child have difficulty sounding out words one sound at a time

Y / N Does your child have difficulty dividing words into syllables?

Y / N Do you notice that your child cannot transfer previously learned spelling rules to new words?

11. Writing/Fine Motor Skills:

Y / N Does your child have difficulty with using pencil and paper to write? *Explain or illustrate:*

Please specify which writing style your child uses for most written work: _____ **Cursive** _____ **Printing**

Y / N Does your child have difficulty writing in a printing style? *Check all that apply:*

- | | |
|---|---|
| <input type="checkbox"/> a) letters do not stay on the line | <input type="checkbox"/> d) letters are not formed correctly |
| <input type="checkbox"/> b) letters are all different sizes | <input type="checkbox"/> e) letters slant at different angles |
| <input type="checkbox"/> c) letters are different distances apart | |

Y / N Is the child writing in cursive yet? *Check all that apply:*

- | | |
|---|--|
| <input type="checkbox"/> a) letters do not stay on the line | <input type="checkbox"/> d) letters are all different sizes |
| <input type="checkbox"/> b) letters are not formed correctly | <input type="checkbox"/> e) letters are different distances apart |
| <input type="checkbox"/> c) letters slant in several directions | <input type="checkbox"/> f) capital & lower case incorrectly used in same word |

Y / N Does the child resist doing written work compositions? _____

Y / N Does the child resist doing any other written work? *What kinds of work?*

Y / N Does the child seem unable to write stories in logical order?

Y / N Does your child have difficulty putting ideas into words?

Y / N Is it very difficult for them to do the physical act of writing them?

Y / N Are written compositions very babyish in content?

Y / N Are sentences very short and elementary?

Y / N Does your child speak with a vocabulary more advanced than is used in written work?

Y / N Is it difficult for your child to organize paragraphs into MAIN IDEAS and supportive details?

Y / N Does your child have difficulty with grammar or mechanics of written language (like capitalization)?

Y / N Does your child have trouble mastering punctuation?

What part of the writing process seems the most difficult? _____

Y / N Have you let your child use a word processor to do written work? *If YES, did it help? Explain:*

Attach at least two written compositions of creative writing and/or other writing samples. If you do not have them with you, please mail or fax at your earliest convenience. These are an important piece of understanding your child's present levels of performance. FAX 757-482-7159 – call first so that the FAX machine may be turned on.

12. Math:

Check the basic number facts that your child knows well. (This, of course, depends on grade level!)

_____ addition _____ subtraction _____ multiplication _____ division

Y / N Does your child prefer reading/writing work over doing math?

Y / N Does your child have difficulty keeping track of time?

Y / N Can your child tell time on non-digital clock (round face with long/short hand) ?

Y / N Are math problem numbers written in irregular or uneven columns or rows on paper? _____ Uneven sizes?

Y / N Does your child frequently do the wrong math operation (e.g., mixing up signs)? *Give examples and **attach:*

Y / N Can your child do estimation?

Y / N Can your child do math in his/her head, without pencil and paper?

Y / N Can your child do math problems with several steps, such as long division or reducing fractions?

Y / N Does your child lose his/her place frequently while doing **math**?

Y / N Does math work wander all over the page, with unevenly sized numbers, crooked columns?

Explain exactly what you see (attach work samples):

Y / N Does your child skip around the page to do math, in contrast to left-to-right and top-to-bottom sequences?

Y / N Does your child have trouble visualizing concepts, amounts of objects, or the location of places?

Give details of other math difficulties that you have observed:

****If you have expressed concerns about your child's MATH work, please provide at least three recent work samples of math computation and word problem-solving.**

13. Processing, Vision, Hearing - Odds and Ends:

Y / N Is your child seeing a physician for eye problems? *If YES, who?*

Y / N Does your child rub his/her eyes frequently, or squint while reading or doing written work?

Y / N Does your child frequently bring his head very close to the page when working or reading?

Y / N Does your child have difficulty with large motor coordination, as in sports, bike riding?

Y / N Do you see your child as awkward, having trouble with sports, dropping things or falling a lot? *Explain:*

Y / N Is there any indication your child cannot hear normally? *If YES, explain on reverse side.*

Y / N Does your child have trouble working or reading pages/workbooks that have lots of "busy" details?

Y / N Does your child lose things frequently?

Y / N Do you notice your child has unusual hyper-sensitivity to noise?

Y / N Does your child seem to strongly resist touching by others? Was this true when he/she was an infant? _____

Y / N Does your child become agitated when closed in by crowds or close spaces?

Y / N Does your child frequently comment or complain about “normal” smells? *Give examples:*

Y / N Have you noticed a particular sensitivity or dislike to the taste, temperature or texture of foods? *Explain:*

Y / N Does your child have a strong dislike or preference for specific fabrics?

Y / N Does your child have “anxieties” that concern you – more severe than “average”?

Please explain and give examples: _____

Y / N Does your child seek or need a lot of physical stimulation - rough handling, bumping walls, *etc.*?

Y / N Does your child seem unable to concentrate if things are “too quiet?” or “too noisy?”? *Which one?*

Y / N Does your child seem to get disoriented in new locations or “feel lost” in new places? *Explain:*

Y / N Does your child avoid eye contact when speaking with you or others? *Since when?* _____

Y / N Does your child seem unable to conduct normal conversation with peers? *With adults?* _____

Y / N Can you recall a time when you noted a **change** in your child’s ability to recall previous learning?

Y / N Does your child seem too focused on a single object or topic -- to the point of excess? *Explain:*

Y / N Does your child seem “overwhelmed” in noisy or active situations (*e.g.*, a noisy restaurant, *etc.*)

Y / N Does your child seem confused when spoken to?

Y / N Can your child orally tell stories aloud in logical order?

14. Other Concerns:

Please add any concerns about your child’s education that were not covered in this questionnaire.

15. What kind of help are you seeking from HIS Place?

Please be as complete as possible (*e.g.*, are you seeking to have an IEP written? To find out why the child is struggling? Wondering if there is a learning disability? *etc.*).

State specifically your greatest concern about your child:

16. Behavioral Concerns:

Y / N Does your child have hard-to-control behaviors that occur *to such a degree that they concern you or others?*

If **YES**, please complete the questions below. If **NO**, this ends the questionnaire.

Y / N Does your child have a behaviors or behaviors *that are causing learning problems* for him or her?

a) What conditions seem to trigger the behavior? _____

b) Are these outbursts sudden and/or way out of proportion to the event that “triggered” them?

c) What are the negative behaviors? _____

d) Is your child seeing a professional for this behavior and/or taking medications? This is something that may impact testing performance and academic performance. Please be as helpful as possible without revealing any confidential information that you would prefer to keep private. Use the space below and attach **copies** of any relevant reports or evaluations. **Please do not bring the originals!** Thanks.

