



PARENT QUESTIONNAIRE FOR PSYCHOLOGICAL ASSESSMENT

Your child/ward has been referred for a **psychological assessment**. Information from this questionnaire will help the psychologist/psychological associate to better understand your child's strengths and needs at school.

Prior to seeing your child at school, the psychologist/psychological associate will contact you by telephone to explain the nature and purpose of the assessment and to make sure that all of your questions about the assessment have been answered. **The primary caregiver, such as a parent or guardian, should complete the following questionnaire.**

Date: _____

IDENTIFYING INFORMATION:

Child's Name: _____ D.O.B.: _____
(mm/dd/yyyy)

Person completing this form: _____

Relationship to Child: _____

At what telephone number can you be reached during regular business hours? home work cell

Telephone numbers: (h) _____ (w) _____ (c) _____

EDUCATIONAL INFORMATION:

When did you first become concerned about your child's progress in school? Grade _____

Please outline your main concerns about your child's progress in school: _____

What school subjects does your child enjoy? _____

What school subjects does your child dislike? _____

How well has your child adjusted to school? ____ Very well ____ fairly well ____ poorly

Does your child enjoy reading? ____ . Does your child enjoy listening to stories? ____

Does your child regularly complete homework? _____

Please comment on your child's attitude toward school, learning, homework completion, etc.:

Have any of the child's siblings had problems in school? **Yes** **No** If **yes**, please provide details: _____

MEDICAL HISTORY AND EARLY DEVELOPMENT:

Did you experience any medical complications during your pregnancy with this child (e.g., preeclampsia, seizures, severe illness)? **Yes** **No** If **yes**, please provide details: _____

Was your child born at the expected date (between 38 and 42 weeks)? **Yes** **No** If **no**, please provide details:

Were there any complications during this child's birth/delivery? **Yes** **No** If **yes**, please provide details: _____

Did your child meet their early motor milestones (e.g., sitting up, crawling, walking, etc.) at about the expected times? **Yes** **No** If **no**, please provide details: _____

Did your child meet their early language milestones at about the expected times (e.g., first word by 1 year; 5-20 words by 18 months; using 2-word statements by 24 months, etc.)? **Yes** **No** If **no**, please provide details: _____

Did your child receive assessment and/or treatment from the Preschool Language Service in your community before school entry or during Junior Kindergarten? **Yes** **No** If **yes**, please provide details: _____

Has your child had his/her hearing assessed? **Yes** **No** If **yes**, at what age? _____ If any concerns were noted, please provide details: _____

Has your child experienced recurrent ear infections? **Yes** **No** If **yes**, at what age? _____ If this continues to be a problem, please provide details: _____

How is your child's general health? Please list any physical impairments, disorders, or ongoing medical problems:

Has your child ever experienced any of the following: head injury; concussion; loss of consciousness; seizures; brain infection; or other serious injury or medical problem? **Yes** **No** If **yes**, please provide details: _____

Has your child had his/her vision assessed? **Yes** **No** If **yes**, at what age? _____

If any concerns were noted, please provide details: _____

List any medications that your child currently takes on a regular basis: _____

INVOLVEMENT WITH OTHER PROFESSIONALS OR AGENCIES:

Please list any special examinations or assessments (e.g., pediatric, psychological, speech & language) or involvement with other agencies (e.g., Pathways for Children & Youth, Children's Aid, Children's Mental Health Services, etc.). Please indicate if a report is available:

Agency/Professional	Date	Findings	Report?

FAMILY / HOME / COMMUNITY:

With whom does your child live? _____

Please list the child's siblings and their ages: _____

If the parents are separated or divorced, who has legal custody? _____

Is English the first language your child learned? **Yes** **No** If no, what other languages are spoken in the home?

Is your child involved in regular activities outside of school (e.g., sports, recreation, music lessons, cadets, etc.)?

Yes **No** If yes, please provide details: _____

How socially involved is your child with other children outside of school? _____

How much time does your child spend watching TV, playing video games, on the phone or computer each day?

BEHAVIOUR AND SOCIAL FUNCTIONING:

For his or her age, do you consider your child to be socially mature; average; immature?

What qualities make your child enjoyable to be around? _____

What things does your child like to do when he or she is not at school? _____

What activities do you enjoy doing most with your child? _____

Please note any of your child's behaviours that you find unacceptable: _____

Please list what you consider to be your child's strengths and weaknesses:

Strengths	Weaknesses

Other comments: _____

The information gathered on this form is collected pursuant to the Education Act, the Municipal Freedom of Information and Protection of Privacy Act, and the Personal Health Information Protection Act. Information will be used to prepare assessment reports and to assist with planning the student's educational program. This information will be used by: Student Services Staff; Principal; Teachers responsible for student's program.