

PARENT QUESTIONNAIRE

Confidential Background Information (Please feel free to write on the back)

Child's Name:

Nickname:

Birth date:

Place of Birth:

Age:

Sex:

Home Address:

Ethnicity:

Parent 1 Name:

Phones:

Email Address:

Occupation and employer:

Education, training, particular background and interests:

Parent 2 Name:

Phones:

Email Address:

Occupation and employer:

Education, training, particular background and interests:

Any other Parent(s) present in child's life and relationship: Phones:

Occupation and employer:

Education, training, particular background and interests:

Child's nuclear family and household (adults and children):

Name	Relationship to child	Age	Living in home
------	-----------------------	-----	----------------

Activities enjoyed as a family:

School attending:

Present Grade:

Child presently likes school, hates school, or is indifferent (circle one).

Describe any neurological areas of concern checked above:

Please briefly describe your child's allergies, ear infections, high fevers, or illnesses and any other distinguishing health history and physical conditions.

Illnesses, hospitalizations, and or operations. Include reason and age of child:

Current medications:

Pediatrician _____ Other physicians seen: _____

Has your child ever developed a temporary tic? Age it started and age it disappeared.
What were the circumstances going on in the child's life when the tic started? When the tic disappeared, did anything change in the child's life?

Sensory Motor:

Vision Screening
Date of latest testing:
Results:

Hearing Screening
Date of latest testing:
Results:

___ has no sensory or motor difficulties
___ has no visual difficulties
___ is to wear corrective lenses
___ has mild hearing difficulties
___ has substantial hearing difficulties
___ eyes do not tract together

___ has an allergy related difficulty
___ is supposed to wear a hearing aid
___ has pressure equalization (P/E) tubes
___ has fine motor movement difficulties
___ has gross motor movement difficulties
___ frequently bumps into things

Can your child ride a bike? Yes No At what age did they start? _____

Energy level and sleep needs:

Was child adopted? _____ If so, at what age? _____

If so, please answer pregnancy questions in terms of child's birth mother if known.

Pregnancy and Birth Information: (please check all that apply)

___ was born with no apparent complications ___ spent time in neonatal intensive care
___ experienced anoxia at birth ___ was born past due date
___ experienced in utero exposure ___ was born premature
___ required assistance with breathing ___ weighed less than 5 _ pounds at birth

Other Pregnancy Issues (include any difficulties, whether mother smoked, drank alcohol, took drugs, medical illnesses, or any health problems of the mother):

Birth Issues (include any other complications, natural versus induced, breech, Apgar score, and duration of pregnancy):

Family History (Include whether anyone else in the family skipped a grade, had high academic achievement, had/has ADHD, dyslexia, seizures, learning issues, etc.)

Developmental History (As best you remember)

Age held head up?_____, age turned over?_____, age smiled at parents?_____
Age crawled?_____, age sat w/o help?_____, age pulled up at crib?_____
Age walked with help?_____, age walked alone?_____, bottle fed?_____
Breast fed?_____, age weaned?_____, age said 4-10 words?_____
Age used sentences?_____, Speech problems?_____
Shy or timid?_____, Likes attention?_____, friendly baby?_____
Affectionate?_____, Wanted to be left alone?_____, stubborn?_____
More interested in things than in people?_____
Ate well?_____, Age fed self_____, Breath holding?_____
Temper tantrums?_____
Tears up toys more than normal?_____, Much too active?_____
Age bowel trained, night?_____, day?_____, Age helped with dressing?_____
Age stayed dry, night?_____, day?_____, Right or left handed?_____
Well coordinated?_____, Clumsy?_____, Good with hands?_____
Blank spells?_____, Fainting spells?_____, Rocking?_____
Dare-devil behavior?_____, Impulsiveness?_____, Head bumping?_____
Unusual fears?_____

Reading Skill Development, (include age read first word, read multiple words, read chapter books):

History of learning English if it is a second language:

Relationship with siblings:

Relationship with mother:

Relationship with father:

Relationship with other children:

Sensitivity:

Sense of humor:

Needs and ways to be in control:

Other Personality Characteristics:

Particular assets and strengths:

Fears, anxieties and other problems:

Favorite activities:

Special lessons and extracurricular activities:

How do you discipline at home? For what problem behaviors? Which motivation and learning methods are usually effective:

Particular reasons for testing and or counseling now:

Any other information that might help your child:

Completed by: _____ Relationship to child _____

Please mail to: Karen Langdon, Director of Admissions, ACE Academy, 3801 N. Capital of Texas Hwy., E240-158, Austin, Texas 78746.

