



ACE Academy
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: _____ Hair Color: _____ Eye Color: _____

FAMILY INFORMATION

Parent 1

Name: _____ Phones: _____

Email Address: _____

Occupation and employer: _____

Education - College and any Post-Graduate work:

School(s): _____ Degree(s) or # of Years: _____ Major(s)/Specialties: _____

Other training, relevant background, and interests:

Parent 2

Name: _____ Phones: _____

Email Address: _____

Occupation and employer: _____

Education - College and any Post-Graduate work:

School(s): _____ Degree(s) or # of Years: _____ Major(s)/Specialties: _____

Other training, relevant background, and interests:

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

Name: _____ Relationship: _____ Phones: _____

Occupation and employer: _____

Education - College and any Post-Graduate work:

School(s):

Degree(s) or # of Years:

Major(s)/Specialties:

Other training, relevant 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:

Relationship with mother:

Relationship with father:

Relationship with siblings:

SCHOOL INFORMATION

School attending: _____ Present Grade: _____

Child presently: likes school / hates school / is indifferent (circle one).

Academic Strengths and favorite school activities:

School problems and concern areas from parents' point of view and concerns teachers have reported about your child. Include length of time any problems have been occurring:

Typical grades in school: _____

Earlier School Experiences:

Number of schools child has attended: _____

Retention in school? Yes / No If so, at what grade level: _____

Reason for retention:

Acceleration in School? Yes / No If so, at what grade level: _____

Reason for acceleration:

PSYCHOLOGICAL, DEVELOPMENTAL, AND MEDICAL INFORMATION

Previous testing information:

Type of Test: _____ Reason for Test: _____ Administered by: _____ Results: _____

Medical/Psychiatric Conditions: (please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> no major medical or psychiatric concerns | <input type="checkbox"/> lead poisoning |
| <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> an attention deficit disorder | <input type="checkbox"/> muscular dystrophy |
| <input type="checkbox"/> an attention deficit hyperactivity disorder | <input type="checkbox"/> a seizure disorder |
| <input type="checkbox"/> chronic ear infections | <input type="checkbox"/> severe allergies |
| <input type="checkbox"/> depression | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> Fetal Alcohol Syndrome |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> other _____ |

Neurological Status: (please check all that apply)

- | <u>In the Past</u> | <u>Recently</u> |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> no signs of neurological concerns |
| <input type="checkbox"/> | <input type="checkbox"/> episodes of head banging |
| <input type="checkbox"/> | <input type="checkbox"/> seizures or convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> a serious head injury |
| <input type="checkbox"/> | <input type="checkbox"/> periods of unconsciousness |
| <input type="checkbox"/> | <input type="checkbox"/> an unusual number of accidents |
| <input type="checkbox"/> | <input type="checkbox"/> a motor tic |

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: _____ Hearing Screening: _____

Date of latest testing: _____ Date of latest testing: _____

Results: _____ 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 without training wheels? 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
 experienced anoxia at birth
 experienced in utero exposure
 required assistance with breathing
 spent time in neonatal intensive care
 was born past due date
 was born premature
 weighed less than 5 ½ pounds at birth

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

Birth Issues (include any other complications, e.g. 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 other children:

Name at least three adjectives that best describe your child:
Other Personality Characteristics:

Particular assets and strengths:

Sensitivity:

Sense of humor:

Needs and ways to be in control:

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: _____

Date: _____

Please mail to:

Karen Langdon, Director of Admissions
ACE Academy
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E 240-158
Austin, Texas 78746

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