

PARENT SURVEY

Student Name _____ Relationship to Child _____

Today's Date _____ Birthdate _____ School _____

Name of Parent(s) _____ Primary Language _____

This information will help in the planning of your student's education. Your comments will be available only to authorized school personnel responsible for working with your child.

1. REASON FOR ASSESSMENT:

- | | | |
|--|---|---|
| <input type="checkbox"/> Reading Difficulty | <input type="checkbox"/> Math Difficulty | <input type="checkbox"/> Writing Difficulty |
| <input type="checkbox"/> Behavior Difficulty | <input type="checkbox"/> Attention Difficulty | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Speech Difficulty | <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Medical Condition |
| <input type="checkbox"/> Social Skill Difficulty | <input type="checkbox"/> Hearing/Vision | <input type="checkbox"/> Other |

Please explain concerns: _____

2. DEVELOPMENTAL HISTORY:

| | Early | Typical | Late | Explain, if late |
|-----------------|-------|---------|-------|------------------|
| Sitting | _____ | _____ | _____ | _____ |
| Crawling | _____ | _____ | _____ | _____ |
| Standing | _____ | _____ | _____ | _____ |
| Walking | _____ | _____ | _____ | _____ |
| Speech | _____ | _____ | _____ | _____ |
| Toilet Training | _____ | _____ | _____ | _____ |

Please report any unusual pregnancy, labor, or delivery complications with this student: _____

3. MEDICAL AND EMOTIONAL INFORMATION:

Is your student under the care of a physician or psychologist? Yes No If yes, list:

Describe any eating or sleeping problems: _____

Is your student on medication? Yes No If yes, please explain:

- | Medication | Reason for taking medication |
|------------|------------------------------|
| A. _____ | _____ |
| B. _____ | _____ |
| C. _____ | _____ |

History of seizures or brain trauma: _____

Does your student wear glasses/contacts? Yes No

Does your student have a hearing deficit? Yes No

Does your student have a medical/emotional condition that may be affecting his/her education?: Yes No Comments: _____

4. EDUCATIONAL HISTORY:

Did this student attend preschool? Yes No

List previous schools attended: _____

Does your student have attendance difficulties? Yes No Explain: _____

What are your student's favorite classes? _____

What classes are difficult? _____

What is interesting and motivating to your student? _____

Has your student received special services or programs in the schools? Yes No

Explain: _____

5. FAMILY INFORMATION:

List all family members:

| Name | Gender | Age | Grade | Medical or Education Concerns |
|-------|--------|-------|-------|-------------------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Has your student experienced any parental separation, divorce, or death? Yes No

Explain: _____

Describe the student's relationship with his father or male guardian: _____

Describe the student's relationship with his mother or female guardian: _____

Describe the student's relationship with his siblings: _____

Describe the student's relationships with friends/peers: _____

6. COMMUNITY INFORMATION:

List any agencies your family may be working with: _____

Has your student been in foster care? Yes No Explain: _____

Is/was your student in: Court Probation Detention