Parent/Guardian Questionnaire

Please Read Before Completing Questionnaire

- Thank you for taking the time to answer the following questions. The information you provide about your child is essential.
- This form needs to be printed and filled out by hand. It can be scanned and emailed or brought along to the initial consultation.
- The Questionnaire is divided into four sections. **If you have been referred by a practitioner at the CDN then only complete Sections 3 and 4.** If you are new to CDN please complete all four sections.
- Please ensure this questionnaire is submitted along with the Teacher Questionnaire.

SECTION 1: PERSONAL DETAILS:

Child's Full Name: _____

Gender Please Circle: Male / Female / Other: Please State _____ Date of Birth: __ __ / __ __ / 20__

Parent / Guardian 1 (Full Name): _____

Contact Number of Parent / Guardian 1: _____

Email of Parent / Guardian 1: _____

Occupation of Parent / Guardian 1: _____

Parent / Guardian 2 (Full Name): _____

Contact Number of Parent / Guardian 2: _____

Occupation of Parent / Guardian 2: _____

Email of Parent / Guardian 2: _____

If Parents / Guardians are separated, please indicate (✓): ❒

How far from the CDN does the child live (or go to school) in Travel Time: _____

School: _____

Year of Schooling (incl Prep):_____ Grade:_____ Age in Years:_____Months: _____

Referred by (please✓): Practitioner (other than GP): ❒ Friend: ❒ Self Referred: ❒

Please tick (✓) if you would like to receive Literacy and Learning information from Dr Jason McGowan and the Literacy Foundation for Children. No more than 4 emails per year: Yes ❒ No ❒

(turn the page)

Level 2, 19 Lang Parade, Milton 4064 PO Box 1536, Milton 4064
(07) 3369 3369 (07) 3369 3370 www.cd.net.au cdn@cd.net.au

jason@cd.net.au www.literacycare.com

SECTION 2: Referral Information, Existing Diagnosed Conditions and Medication

Child's Full Name: _____ Date of Birth: _____

1. Were you referred by a clinician who is at CDN (Please Tick ✓) Yes ❒ (go to SECTION 3 on Page 3)
   No ❒ (complete SECTION 2)

   a Name of referring clinician: _____

   b Do you have a referral letter or report? (Please Tick ✓) ❒ Yes or ❒ No (Please note: a referral letter is not required but please bring referral letter/report if you have one)

   c What was the main reason you saw the referring clinician? _____

2. Do you intend seeing another clinician at the CDN (Please Tick ✓) Yes ❒ or No ❒

   If yes, who? _____

   When do you expect to see this professional? _____

Diagnosed Conditions and Medication

1. Has your child been formally diagnosed (by a Medical Practitioner, Psychologist or other Specialist withany of the following? (Please Tick ✓)

   ❒ Anxiety Disorder
   ❒ Attention Deficit Hyperactivity Disorder
   ❒ Autistic Spectrum Disorder
   ❒ Developmental Language Disorder
   ❒ Dyscalculia
   ❒ Dysgraphia
   ❒ Dyspraxia
   ❒ Dyslexia
   ❒ Hearing Difficulties
   ❒ Non-Verbal Learning Disability
   ❒ Oppositional Defiant Disorder
   ❒ Vision Difficulties
   ❒ Working Memory Difficulties
   ❒ Other: _____

2. Is the child on any medication relative to learning or behaviour? (Tick ✓) Yes ❒ or No ❒

   If yes, please give details: _____

(Continue to SECTION 3)

(turn the page

SECTION 3: LITERACY AND LEARNING QUESTIONS:

Child's Full Name: _____ Date of Birth: _____

Strengths and Interests?

Is your child average or better in any of the following areas: (Please ✓)

❒ Sport	❒ Music	❒ Art	❒ Creative
❒ I.T	❒ Construction	❒ Story Telling	❒ Perceptive and Intuitive
❒ Acting/Drama	❒ Vivid Imagination	❒ Designing	❒ Spatial Awareness

Please write a short comment on the following:

Organizational Skills: _____

Ambitions: _____

Non-Academic Interests: _____

_____

Social skills relating to family: _____

_____

Social skills relating to friends: _____

_____

Questions, Concerns, Outcomes

Overall, how concerned (worried) are you about your child? Use the Scale below to help you answer

1	Not at All	2	Somewhat	3	Moderately	4	Quite a Lot	5	Extremely

(Please Circle a Number)

Parent / Guardian 1 ***1 2 3 4 5***

Parent / Guardian 2 ***1 2 3 4 5***

What outcome(s) would you like Literacy Care to achieve for your child?

_____

_____

_____

_____

(turn the page)

SECTION 3 Continued

Child's Full Name: _____ Date of Birth: _____

Do you believe your child's learning and or literacy development has been negatively influenced by any of thefollowing?

	Please ✓	If Yes, Briefly Explain
Anxiety	❒	
Attention and Concentration	❒	
Sleep Patterns or Fatigue	❒	
Diet and Eating Habits	❒	
Developmental Problems	❒	
Major Accidents	❒	
Major Illnesses	❒	
Major Injuries	❒	
Family Conflict/Separation	❒	
Abuse	❒	
Other	❒	

Hereditary Factors

Does anybody in the family (siblings, parents, grandparents, aunts, etc have problems **similar** to, or the **same as** your child?	❒ Yes	❒ No

If yes, please briefly explain: _____

Does anybody in the family (siblings, parents, grandparents, aunts, uncles etc) have **different** problems, of a developmental, learning, behavioural, emotional or psychiatric nature?	❒ Yes	❒ No

If yes, please briefly explain: _____

Previous Professional Involvement and Management

Who have you consulted for your child's difficulties?

	Currently [✓]	In the Past [✓]	Name:
Paediatrician	❒	❒	
Child Psychiatrist	❒	❒	
Occupational Therapist	❒	❒	
Speech Pathologist	❒	❒	
Psychologist	❒	❒	
Social Worker/Counselor	❒	❒	
School Guidance Officer	❒	❒	
Learning Support Teacher	❒	❒	
Home Tutor / Study Centre	❒	❒	

(turn the page)

SECTION 3 Continued

Child's Full Name: _____ Date of Birth: _____

Academic and Scholastic Interventions and Information

Please name/describe all educational programs and or interventions in which your child has participated. If none, please write 'Nil'

_____

_____

_____

Please circle the level that best describes your child's general academic and scholastic progress:

Well Below Average Below Average Average Above Average Well Above Average

Which is your child's best subject? _____

Does your child have a Personalized Learning Plan or equivalent at school? ❒ **Yes** ❒ **No**

If so, what? _____ **When did the plan commence?** _____

Complaints by the child or observations by adults (parents/teachers) about written text and classroom behaviour relative to learning. (Please ✓)

1. Words moving on the page	❒
2. Colours appearing on the page (flickers or flashes)	❒
3. Hard to read under florescent light	❒
4. Bothered by glare	❒
5. Premature fatigue when doing schoolwork	❒
6. Attention and concentration problems in class setting	❒
7. Stares into space and appears vague	❒
8. Easily overwhelmed by verbal instructions	❒
9. Forgets instructions almost straightaway	❒
10. Relies on watching other children to figure out what to do	❒
11. Low written output	❒
12. Has great ideas but can't put them into written words	❒
13. Procrastinates. Can't get started with schoolwork	❒

SECTION 3 Continued

Child's Full Name: _____ Date of Birth: _____

When you come to see us:

1. Is there sensitive information that you would prefer not to talk about in front of your child?

   ❒ Yes - Please briefly state this so it can be avoided _____
   ❒ No

2. So that we can remember you and your child, we would like to take a photograph of those who attend the initial consultation. Usually the photo is of parents/guardians and child together. This photograph is pasted into your child's electronic file. Do we have your permission to take a photograph of you together with your child? (Please feel free to submit a photo of your choice).

   ❒ Yes
   ❒ No

SECTION 4: Parent / Guardian Name and Signature

Child's Full Name:_____Date of Birth: _____

Completed by: (Please Print Name) _____

*Signature:*_____*Date:*_____/_____/ _____

Thank you for taking the time to complete this questionnaire.