**Parent/ Carer Questionnaire**

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| **Contact Information** |
| Name of Parent/ Carer(s): |  |
| Home Address: |  |
| Contact telephone number: |  |
| Contact email: |  |
| Name of child: |  |
| Child’s Date of Birth: |  |
| Country of Birth (and date moved to UK if applicable) |  |
| How does the child identify themselves? | Male Female Non Binary Prefer not to Say |
| School Year: |  |
| Is the child adopted or in foster care? | Yes No Prefer not to Say |
| What are your main concerns?(Please give a bullet point outline and add details at the end) |  |

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| **Early Development** |
| Was birth at full term with a normal delivery?If no, please provide further details |  |
| Did your child meet all usual developmental milestones?(e.g. walking, talking, riding a bike etc.) |  |
| Has your child ever had any Speech and Language difficulties? | lf yes, please describe these difficulties (such as understanding the meaning of words, expressive language, speech clarity, pronunciation, word finding difficulties and if they had any speech and language therapy): |
| Is there a history of ear infections, glue ear or grommets? |  |
| Are there any hearing problems? |  |

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| **Vision and Visual Difficulties** |
| Please ensure that your child has had an up to date **sight test.** In some cases, difficulties with reading are caused by **visual difficulties**. Please read the list below. If you answer Often or Always to several questions, you must discuss this at the eye test so that the Optometrist carrying out the eye test can refer your child to an Ophthalmologist for further investigation prior to the assessment. It is important that this is ruled out.  |
| **Section for parents/carers** | **Never** | **Rarely** | **Sometimes** | **Often** | **Always** |
| Does your child report headaches when they are reading? |  |  |  |  |  |
| Does your child report that reading makes their eyes feel sore, gritty or watery? |  |  |  |  |  |
| Does your child report feeling tired or sleepy during or after reading? |  |  |  |  |  |
| Have you noticed your child become restless, fidgety or distracted when reading? |  |  |  |  |  |
| Have you noticed your child rubbing their eyes when they are reading? |  |  |  |  |  |
| Have you noticed your child screwing up their eyes when reading? |  |  |  |  |  |
| Have you noticed your child tilting their head to one side when reading? |  |  |  |  |  |
| Have you noticed your child moving their eyes around or blinking frequently when they are reading? |  |  |  |  |  |
| Have you noticed your child holding a paper or book very close to their eyes when reading? |  |  |  |  |  |
| How often does your child use a marker or their finger to keep their place when reading? |  |  |  |  |  |
| Have you noticed that your child frequently loses their place when reading? |  |  |  |  |  |
| Have you noticed your child covering or closing one eye when reading? |  |  |  |  |  |
| **Section for child** |
| When you read, do you see two of each word? |  |  |  |  |  |
| When you read, do the words you read look blurry (or fuzzy, or unclear)? |  |  |  |  |  |
| When you are reading, do the words move on the page? |  |  |  |  |  |
| When your teachers ask you to copy something from a screen at the front of the classroom, can you see what is written on the screen? |  |  |  |  |  |

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| **Vision and Visual Difficulties Continued** |
| Has your child had any history of visual difficulties / problems with sight / visual impairment? | Yes | No |
| lf yes, provide further details: |
| Does your child wear glasses?  | Yes | No |
| lf yes, provide details (i.e. for near work, watching tv etc) **and ensure glasses are brought to the assessment**:  |
| Has your child ever used coloured overlays / colour-tinted glasses?  | Yes | No |
| If yes please provide the following information: Who recommended them and why? Did they help? If yes, in what way?Does your child still use them? If not, why not? |
| **Reading and Near Work Activity**  |
| Approximately how many hours per school day does your child spend at a screen (phone, tablet, computer) etc? |  |
| Approximately how many additional hours per school day does your child spend reading books, newspapers, comics or other paper-based texts? |  |
| Has your child’s screen /reading /near work time increased recently? If so, by how much? |  |

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| **Family History** |
| Have any family members experienced difficulties with spelling/ reading/ learning. If yes, please give details.  |  |
| **Language and Linguistic History** |
| Are any languages other than English spoken at home? |  |

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| **Educational History** |
| How has school experience been so far? Does your child enjoy school?Are there any particularly loved or hated subjects? |  |
| Has your child’s schooling been disrupted in any way? |  |
| Have any of your child’s teachers discussed any difficulties your child is experiencing? |  |
| Did your child pass the Phonics Test in Year 1? |  |
| Has your child seen any other specialists (e.g. Educational Psychologist, Advisory Teacher etc)?  | *If yes, please provide copies of reports.* |
| Is there any specialist help currently given at school? | *If yes, please give details (e.g. Teaching Assistant, specialist tuition, extra time)* |

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| **What are the particular difficulties currently exhibited in school?** |
| **Reading** | Slight | Moderate | Severe |
| **Spelling** | Slight | Moderate | Severe |
| **Writing** | Slight | Moderate | Severe |
| **Mathematics** | Slight | Moderate | Severe |
| **Sports and Games** | Slight | Moderate | Severe |

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| **Literacy** |
| Please describe your child’s current strengths and difficulties with Literacy |  |
| Does your child have difficulty recalling the alphabet or other known sequences (e.g. months of the year)? |  |
| **Numeracy** |
| Please describe your child’s current strengths and difficulties with numeracy |  |
| Does your child have difficulty with telling the time? |  |

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| **Memory, Attention and Concentration** |
| Does your child have difficulties with memory, attention and concentration?If yes, please provide details.  |  |
| **Speech, Oral Language, Communication and Social Skills** |
| Are there any current difficulties with speech, oral language or communication? |  |
| Does your child have difficulties with social skills, behaviour, peer relationships or emotional adjustment? |  |
| Does your child have difficulties with self-esteem and confidence? |  |

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| **Organisational Skills** |
| Does your child have good organisational skills?Please provide details |  |

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| **Fine and Gross Motor Skills** |
| Does your child have any difficulties with fine motor skills (e.g. holding a pencil, knife and fork) |  |
| Does your child have any difficulties with gross motor skills (e.g. catching a ball, balancing, climbing) |  |
| Does your child get confused between left and right? |  |

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| **Strengths** |
| Please provide information about your child’s strengths, what they are good at, hobbies they enjoy etc.  |  |

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| **Any other information** |
| Please use this space to mention any other difficulties or concerns which have not been covered above |  |

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| Signed: |  | Print name: |  |
| Relationship to Child: |  | Dated: |  |