**Parental Questionnaire**

Thank you for taking the time to complete this questionnaire.

The information that you supply will help me to better understand the needs of your child so please provide as much detail as possible.

If you have any questions regarding this questionnaire, please feel free to contact me on 07752315202 or email me at holtdyslexiatutoring@gmail.com.

Rest assured that the information provided in this questionnaire is confidential and will not be shared with anyone else.

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| **Personal Information** |

 **Please indicate who is completing the form and your relationship to the young person:** ­­­­­­­­­­­­­­ |

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| **Child’s Full Name** (required) |
| **Date of Birth** (required) |
| **School Year** (required) |
| **Country of birth**  |
| **Date moved to the U.K.** |
| **How does the child identify themselves?** (please circle)  Male female non-binary prefer not to say |
| **Name of parent/ carer** (required) |
| **Home address** (required) |
| **Contact telephone number** (required) |
| **Contact email** (required) |

**Health and Developmental History**

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| Were there any difficulties during pregnancy or the birth of your child? Yes NoIf yes please provide further details: |
| Were there any difficulties with feeding, sleeping, dressing or left/right confusion? Yes NoIf yes please provide further details: |
| Were all developmental milestones reached e.g. crawling, walking, talking, using cutlery, toileting, riding a bike? Yes NoIf no please provide further details: |
| Has your child ever had any Speech and Language difficulties? Yes Nolf 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? Yes NoIf yes please provide further details: |

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| **Vision and Visual Difficulties** |

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| **To continue with this assessment, it is imperative that your child has undergone a sight test within the last 6 months.** **In certain instances, challenges with reading may stem from visual difficulties not related to learning. Therefore, if, after responding to the questions below, you suspect any visual difficulties, it is essential to address this during the eye test. This will enable the Optician (Optometrist) conducting the test to refer your child to an Ophthalmologist for further examination before proceeding with the assessment.****Visual difficulties should be investigated if you answered ‘always’ or ‘sometimes’ to several questions.** |
| **Date of your child’s last sight test:** Has your child had any history of visual difficulties / problems with sight / visual impairment? Yes NoIf yes please provide further details: |
| Does your child wear glasses? Yes Nolf 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 NoIf 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? |
| Are there any history of visual difficulties/problems with sight / visual impairment? (This can include problems with glare when reading or skipping lines, missing out words, rubbing eyes when reading, etc) |

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| **Reading and Near Work Activity** |

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| 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? |
| **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? |  |  |  |  |  |
|  | **Never**  | **Rarely** | **Sometimes** | **Often**  | **Always** |
| 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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| **Hearing** |

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| Has your child had any history of hearing problems? Yes No(if yes please provide details e.g. glue ear, recurrent ear infections, grommets) |
| Is your child’s hearing within normal limits? Yes No(If no please provide details) |

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| **Family History** |

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| Are there any other children in the family? Yes No(if yes, please provide details of the family e.g. 2 siblings: older sister, and younger brother) |
| Does your child live with both parents ? Yes No |
| Is your child adopted? Yes No |
| Have both parents been involved in completing this questionnaire? Yes No |
| Any further comments about family background? |
| Does anyone in the family have any of the following specific learning difficulties?(if yes please provide details e.g. their relationship to the child and describe the difficulties)* Dyslexia
* Dyspraxia
* Dyscalculia
* Autism
* ADHD
* Other
* None of the above
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| **Language and Linguistic History** |

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| What Languages are spoken at home? |
| At what age did your child say their first words? |
| At what age were they able to put two / three words together? |
| Have they ever experienced difficulties with pronunciation / speech articulation / any particular sounds that your child could not / cannot say? |
| If English is not your child’s first language, how long has English been spoken? |
| Does your child experience difficulties in their first language and how does this affect them? |
| Was your child able to learn nursery rhymes and early songs easily? |
| Is your child talkative? Do they enjoy songs and rhymes? |
| Has your child ever been assessed by a speech therapist? Yes No(if yes please provide details/ report) |
| Does your child experience any difficulties with following instructions? Yes No(If yes please provide details)  |
| Is there anything else you would like to mention concerning speech and language skills? |

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| **Educational History** |

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| Did your child attend a nursery or playgroup before starting school? Yes No |
| Did they receive any extra support at nursery or playgroup? Yes No(If yes please provide details) |
| What is your child’s attitude toward school? |
| Has your child received extra support at school? Yes No(if yes please describe when, how often and in which subjects) |
| Has your child received extra support outside of school Yes No(If yes please describe when, how often and in which subjects) |
| Has your child ever been assessed previously by any other professional e.g., Occupational Therapist? Yes No(If yes please provide details/ report) |
| Did your child pass the Phonics Test Yes NoIf yes when Year 1 Year 2 |
| Has your child’s schooling been disrupted in anyway e.g., Covid, illness? Yes No(If yes please provide details) |
| Which subjects does your child like best and why? |
| Which subjects does your child dislike and why? |
| What are your concerns about your child’s education and development? |
| What would you like your child to have more help with? |
| How does your child cope with exams and tests? |
| Does your child read or write for enjoyment? |
| Have any of your child’s teachers discussed any difficulties that your child is experiencing? Yes No(if yes please provide details)  |
| Has your child been placed on a special needs register at school? If so why? |
| Does your child have an individual education plan (IEP) or provision map? If so, can you provide an overview of what it contains? |

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| **Current Situation** |

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| Current National Curriculum Levels (if appropriate) |
| English: |
| Maths: |
| 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** |

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| Please describe your child’s current strengths and weaknesses with Literacy. |
| Does your child have difficulty sequencing the alphabet or other known sequences? Yes No(If yes please provide details) |

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| **Numeracy** |

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| Please describe your child’s current strengths and weaknesses with Numeracy. |
| Can your child tell the time on an analogue watch? Yes No |

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| **Memory, Attention and Concentration** |

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| Does your child have difficulties with memory, attention, and concentration? Yes No(if yes please provide details) |

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| **Social Aspects** |

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| Does your child make friends easily Yes No(if no please provide details) |
| Have you ever had concerns about your child’s ability to make friends and socialise?  Yes No(if yes please provide details) |
| Have you ever had concerns about your child’s behaviour or emotional adjustment? Yes No(if yes please provide details) |
| Does your child have or has ever had difficulties with self-esteem and confidence? Yes No(if yes please provide details) |
| Does your child have any hobbies? |

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| **Fine and Gross motor skills** |

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| Does your child have any difficulties with fine and gross motor skills e.g. body awareness, movement, and balance? Yes No(if yes please provide details) |
| Does your child experience left right confusion Yes No |

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| **Dyspraxia / DCD Checklist** |

I cannot diagnose dyspraxia/DCD. However, this checklist is designed to help me to spot the difficulties some children may have

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|  | Yes | No |
| Difficulty with P.E. or Sports, especially team games |  |  |
| Difficulties with playing team games, such as football, volleyball, catching or throwing balls accurately? |  |  |
| Poor posture, unusual gait, or awkwardness of movements. May be hypermobile |  |  |
| Has difficulty learning to ride a bike compared to your peers? |  |  |
| Bump into objects or people, trip over things more than others? |  |  |
| Poorly developed laterality with learner swopping hands for different tasks. Confusion between left and right.  |  |  |
| Handwriting difficulties – style, speed, and/or unusual pen/pencil grip |  |  |
| Has difficulty writing neatly (so others could read it)? |  |  |
| Has difficulty writing as fast as their peers? |  |  |
| Difficulties with scissors |  |  |
| Has difficulty eating without getting dirty? |  |  |
| Has difficulties with self-care tasks, such as tying shoelaces, fastening buttons and zips? |  |  |
| Poorly developed organisational skills |  |  |
| Difficulty with e.g. planning essays, sequencing etc.  |  |  |
| Difficulties with awareness of time |  |  |
| Tires easily, needs more sleep or rest than peers |  |  |
| May show phobias, obsessive or immature behaviour |  |  |
| Oversensitive to light, sound and/or heat – sensory issues.  |  |  |
| Evidence of mood swings with highly excitable behaviour on occasion |  |  |
| Does not seem as aware of danger as peers |  |  |
| Difficulty acquiring social skills e.g. forming and maintaining friendships.  |  |  |
| Interrupts or talks too loudly |  |  |
| Takes longer to process information |  |  |
| Poor short term visual and/or verbal memory |  |  |

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| **Any other information** |

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| Please use the space below to summarise your child’s difficulties and your particular concerns, including your concerns about other potential Specific Learning Difficulties (SpLDs). If you do not have enough room below then please add a separate sheet. |

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| Do you consent for the information provided in this questionnaire to be used in your child’s report?*(Required)*  Yes NoSignature:  |
| Do you consent to your name, telephone number and email address to be held by the assessor for the purposes of communication? Yes No Signature: |
| All the information collected in this form will be held in the strictest confidence.  |

AUTHORISATION

* I/we instruct Mrs Deborah Holt to arrange for an assessment to be carried out on my/our child.
* I/we confirm that:
	+ I/we have received, read and accept the Terms and Conditions.
	+ I/we have explained the reason for the assessment to my/our child
	+ the information provided in this Questionnaire is, to the best of my/our knowledge, correct
	+ I/we will pay for the assessment
	+ I/we will respect the confidential nature of the assessment report and only circulate it to relevant professionals and for the purpose for which it was intended
	+ I/we will ensure access to the assessment report by all persons with parental responsibility for my/our child
	+ If you child is over 13 they need to give their permission for this questionnaire to be shared. Do they agree to it? Yes/No

Please note that the information recorded within this questionnaire will be used for the purpose of assisting the assessment. It is possible that some of this information may be recorded within the final assessment report. If you do have any sensitive or confidential information that you think is relevant, but which you either do not want to record or be recorded within the report, then please consider sharing this confidentially with the person performing the assessment and obtain agreement on how this information is to be used. Signed:……………………………………………………….…………………………………

Print name/s:………….…………………………………….…………………….….………

Relationship to child:……………………………………….… Date:…………………………………………

\*If payment is to be made by another person or organisation, such as a bursary fund, please give details here: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Please ask your child’s school to complete the School Questionnaire and forward it.