CITY MONTESSORI SCHOOL
SOMEDAY I'LL CHANGE THE WORLD

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PORT ELIZABETH

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PARENTS' QUESTIONNAIRE

DEMOGRAPHICS

Your child's full name: _____

Primary Language spoken at home: _____

Father/Stepfather/Guardian's Name: _____ Age: _____

ID number _____ Occupation: _____ ___

Employer _____ Business phone _____

Cell number: _____

Mother/Stepmother/Guardian's Name: _____ Age: _____

ID number _____ Occupation: _____ ___

Employer _____ Business phone _____

Cell number: _____

Significant Adults Not Living with the Child:

Age: ___

1. Name: _____

Relationship to child: _____

Extent of involvement with child: _____

2. Name: _____

Age:___

Relationship to child: _____

Extent of involvement with child: _____

A: REASON FOR Application

Describe below the difficulties, if any, which your child is currently experiencing. Please include a brief history.

_____

_____

_____

_____

Please list any known diagnoses (if applicable): _____

_____

Does the student have any siblings? Do any of these siblings have any difficulties? Briefly describe

NAME OF CHILD	SEX	AGE	DIFFICULTIES

B: PREGNANCY, BIRTH AND DEVELOPMENT

Please include any significant information about your pregnancy, birth of your child and their development; you feel is important to gain a full picture of the difficulties your child is experiencing now.

_____

_____

_____

_____

_____

_____

_____

_____

Please rate your child's development on the following skills (✓ on line) during the EARLY YEARS:

	Good	**Average**	**Poor**
Walking	_____	_____	____
Running	_____	_____	____
Jumping	_____	_____	____
Skipping	_____	_____	____
Throwing	_____	_____	____
Catching	_____	_____	____
Buttoning	_____	_____	____
Tying Shoelaces	_____	_____	____
Cutting with Scissors	_____	_____	____
Athletic Ability	_____	_____	____

If you can recall the age at which your child reached the following developmental milestones, please fill in the column under age. If you cannot recall, ✓ one of the items (early, average or late)

	Age (month)	**Early**	**Average**	**Late**
Smiled	_____	_____	_____	____
Sat without support	_____	_____	_____	____
Crawled	_____	_____	_____	____
Stood without support	_____	_____	_____	____
Walked without assistance	_____	_____	_____	____
Spoke first words (not mama/dada)	_____	_____	_____	____
Said phrases	_____	_____	_____	____
Pronunciation clear to strangers'	_____	_____	_____	____
Spoke in sentences	_____	_____	_____	____
Toilet trained	_____	_____	_____	____
Rode a bike without training wheels	_____	_____	_____	____
Buttoned clothing	_____	_____	_____	____
Tied shoelaces	_____	_____	_____	____
Named colours	_____	_____	_____	____
Said alphabet in order	_____	_____	_____	____
Learned to read	_____	_____	_____	____

C: MEDICAL HISTORY OF CHILD

Current:

Child's present height, weight and general appearance: _____

_____

Are any medications currently being taken by your child? If yes, please list and explain: _____

_____

_____

_____

_____

Does this medication need to be administered during school hours? If so, how often _____

_____

Any special eating problems? _____

Any food allergies? _____

Any other allergies that we should know of? _____

_____

What does your child often complain about? (E.g., dizziness, stomach-ache) _____

Does your child have any recurring illness/infection or physical problem of which we should be aware of e.g. Asthma, Epilepsy etc.? If so, please specify and how often. _____

_____

_____

_____

Medical History:

Did your child have? (Please ✓ to indicate)

Measles ____ Whooping Cough _____ Mumps _____

Chicken Pox ____ Pneumonia_____ Diphtheria _____

Scarlet Fever ____ Polio _____ Influenza _____

Was your child out of school during any of these diseases? Please specify, and describe your child's reaction to the illness. _____

_____

_____

Has your child had any other diseases? If yes, please describe _____

_____

_____

_____

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

Any operations? If yes, please explain: _____

_____

_____

Any hospitalisation for illness other than operations? If yes, please explain: _____

_____

_____

Any head injuries? If yes, please indicate whether your child lost consciousness and describe: _____

_____

Has your child displayed any of the following: persistent headaches, dizziness, insomnia, or change in weight? If yes, please explain: _____

_____

_____

Has your child ever had an extremely high fever? If yes, please give age and describe: _____

_____

_____

Any convulsions? If yes, please explain: _____

_____

_____

Any general allergies? If yes, please explain: _____

Any eye or ear problems? If yes, please explain: _____

_____

Does your child wear glasses? _____

Has your child ever been administered oxygen? If yes, please give age and explain: _____

_____

_____

Any history of abuse? If yes, please explain severity and duration: _____

_____

_____

Any family history of neurological or psychiatric illness? If yes, please list and explain: _____

_____

_____

Any history of seizures in the family? _____

D: EMOTIONAL AND SOCIAL DEVELOPMENT OF CHILD Do any of the below apply to your child? (Please ✓ to indicate)

Biting ____ Highly strung ____ Sensitive ____ Insecure ____ Tense ____ Temper tantrums ____

Anxious _____ Happy ____ Relaxed ___ Stubborn ____ Confident ____ Shyness ____

Aggression ____ Outgoing ____ Domineering ____ Competitive ____ Uncooperative ____

Other: _____

Approximate time your child goes to bed and to sleep during the week: _____

Approximate time they wake up in the morning during the week: _____

Any other information that will help us understand your child better e.g. divorce, separation etc…_____

_____

_____

Relationships

Describe your child's relationship with his/her father/stepfather, and what forms of discipline are most often used? _____

_____

_____

_____

Describe your child's relationship with his/her mother/stepmother, and what forms of discipline are most often used? _____

_____

_____

Describe your child's relationship with his or her brothers and sisters: _____

_____

_____

Has your child been in contact with any unusual or odd family, friends, neighbourhood or community? influences? If yes, please describe _____

_____

_____

Describe your child's relationships with peers and close friends: _____

_____

Describe the neighbourhood in which your child lives (safety, opportunities for play or recreation, facilities, etc...) _____

_____

E: STRENGTHS AND INTERESTS

What are your child's main hobbies and interests? _____

_____

_____

What are your child's areas of greatest accomplishment? _____

_____

_____

What strengths do you notice in your child? _____

_____

_____

Any other traits or difficulties, which your child may have, which would help us to understand him/her?

_____

_____

_____

F: ACADEMICS (if applicable)

Please ✓ on the line, which best describes your child's academic performance in each area.

THIS YEAR:

	Poor	Weak	Average	Good	Excellent
Reading	_____	_____	_____	_____	_____
Arithmetic	_____	_____	_____	_____	_____
Spelling	_____	_____	_____	_____	_____
Writing	_____	_____	_____	_____	_____

LAST YEAR:

	Poor	Weak	Average	Good	Excellent
Reading	_____	_____	_____	_____	_____
Arithmetic	_____	_____	_____	_____	_____
Spelling	_____	_____	_____	_____	_____
Writing	_____	_____	_____	_____	_____

Did your child attend pre-school? YES_____ No_____ If yes, how many years? _____

Age your child entered Grade 1: _____

Has your child repeated any grades? If yes, which one(s): _____

Please list the schools attended by your child (including pre-schools):

Name and Location	**GRADES**	**Dates Attended**

G. CURRENT FUNCTIONING DO any of the below apply to your child? (Please ✓ to indicate)

Motor Functioning:					
Muscle Weakness		Lack of coordination		Tremors in the limbs	
Fatigue		Right-left disorientation		Stiffness	
Gross motor difficulties (walking, running, jumping)		Restricted range of movement		Fine motor difficulties (cutting, writing)	
Auditory Functioning:					
Any hearing loss		Processing difficulties		Sensitive to sound	
Tactile Functioning:					
Numbness		Less sensitive to pain		Loss of sensation	
Visuo-spatial Functioning:					
Needing glasses		Colour-blind		Gets lost easily	
Language Ability:					
Problems Comprehending speech		Responding to directions/ instructions		Stutter	
Memory Processing problems:					
Sort term memory		Long term memory		Remote memory (recalling facts)	
Higher Cognitive Processes:					
General Intelligence Functioning		Difficulty coping in school		Difficulty in efficiency in planning	
Organisational Skills difficulties		Problem solving difficulties			

Personality:

Have you, relatives or friends noticed any personality change in your child? (i.e. change in mood, change in thinking, change in behaviour) _____ .

If yes, please describe _____

_____

_____

Self –concept (How does the child feel about him/herself and his/her problems)? _____

_____

_____

Any changes in sexual awareness or behaviour? _____

How does the child function in unstructured situations (e.g. what do they do in their free time? How do they interact with their peers?) _____

How does your child feel about a possible change in schools? _____

_____

Behaviour:

Please ✓ **any of the following behaviours that are typical of your child:**

____ overeats	____ impulsive reactions	____ loss of control
____ suicide attempts	____ withdrawal	____ nervous habits
____ difficulty concentrating	____ vomiting	____ difficulty sleeping
____ takes too many risks	____ lazy	____ eating problems
____ aggressive behaviour	____ crying excessively	____ outbursts of anger
____ drinks alcohol	____ fitful sleep	____ nausea

Please list the names and addresses of any Professional consulted, why they were consulted, as well as the dates of the consultations.

1. Name: _____

Date: _____

Email address: _____

Position: _____

Reason for assessment/appointment: _____

_____

Was an assessment carried out? (circle) YES NO

Date: _____ Type of assessment: _____

Diagnosis if applicable (Please attach report) _____

2. Name: _____

Date: _____

Email address: _____

Position: _____

Reason for assessment/appointment: _____

_____

Is your child currently receiving any of the below therapies on a regular basis? Please fill in details below:

	Name of therapist	How often are sessions attended
Speech and Language Therapy		
Occupational Therapy		
Physiotherapy		
Counselling/ Clinical Psychologist		
Psychiatrist		
Remedial Therapy in:		

Signature: _____ Date: _____

Print Name: _____

Relationship to Child: _____

All information is confidential and will only be used by appropriate personnel. The information you provide will help in the assessment of your child.

Thank you.