

Charted Waters Education Consulting

EDUCATIONAL THERAPIST/CONSULTANT PARENT QUESTIONNAIRE

Please fill out this form as best as you can and use the backs of the pages for extended answers. Please skip questions that are answered in shared reports or not pertinent to your child's needs. All information will be regarded as confidential within the parameters of our signed agreements.

Child's Name: _____ Birthdate: _____

Gender: _____ Age: _____ Grade: _____ School: _____

Ethnicity: _____

Primary Language: _____ Other languages spoken: _____

Parent/Guardian: _____ Occupation: _____

Home telephone: _____ Work telephone: _____

Cell: _____ Email: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian: _____ Occupation: _____

Home telephone: _____ Work telephone: _____

Cell: _____ Email: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Name of person completing form: _____

Relation to the child: _____

Who else did you consult while completing this form?:

Relation to the child?:

Who were you referred by?: _____

What is your goal in seeking educational consulting? How would you like me to support you?

SCHOOL HISTORY

Present School: _____ Grade: _____

Previous Schools attended and years of attendance: _____

BIRTH, MEDICAL and TESTING HISTORY

1. Please describe any complications or special circumstances surrounding birth.

2. Please describe any motor (sitting, crawling, walking) and/or speech development (first words, naming objects, sentences) Did your child experience a delay, meet, or exceed projected milestones?

3. Has there been a history of ear infections? If so, please describe.

4. Has your child ever taken medications for ADD/ADHD or any other condition that may impact their learning (e.g. depression, anxiety, etc...)? If so, please explain.

5. Has your child ever had a head injury? When? How serious? Hospitalized?

6. Please list any previous testing or evaluations done either by school districts, colleges, psychologists, speech pathologists, educational therapists, etc. (please include copies of any reports and IEPs, or 504 plans)

7. Describe your child's sleeping patterns, both weekday and weekend.

8. Would you say your child has a healthy diet (no strong aversions or allergies, and eats on a regular schedule)?

SCHOOL/LEARNING EXPERIENCES

1. Alternate paths: Has your child been homeschooled, repeated a grade or dropped out of school? Please explain.

2. Describe your child's strengths and areas of passion.

3. Describe your child's outdoor activities and other active pursuits.

4. Describe your child's challenges.

5. How does your child feel about school? What are his/her favorite and/or least favorite things about school?

6. How does your child relate to peers? Does your child have many friends, prefer older or younger friends? or have difficulty establishing and maintaining friendships?

7. How does your child deal with transitions to new situations such as embarking on a new school year or trying a new and unfamiliar activity?

8. Is there a particular subject area that your child enjoys, shows advanced or above grade level ability?

9. Has your child ever skipped a grade or done a subject level acceleration in an academic content area?

10. Does your child have difficulty in any of the following areas? Please highlight all that apply.

Speech Reading Writing Spelling Mathematics/Arithmetic

Please provide specific details below of any of the difficulties you circled above.

11. Does your child have any organizational difficulties?

12. Do you have other concerns about your child's school life and academic performance that have not been shared above?

