SPRINGFIELD CENTER FOR
DYSLEXIA & LEARNING

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Questionnaire for Child and Adolescent Clients

Please complete this form to help in understanding the client referred to us. If extra space is needed, please feel free to attach additional pages for your comments.

Date: _____
How did you hear about us? _____
Who Completed this form? _____
Did you receive a screener through our organization? _____

I. IDENTIFYING INFORMATION

Client's Name_____Sex_____Age_____
Date of Birth_____School_____
Current Grade_____
Client Lives with_____
At_____
(Address, City, State, Zip Code)

_____ _____ _____
(Area Code & Home Number) (Cell Phone Number) (E-mail Address)

*Best number to use in order to contact you_____

List names, as appropriate:

Father_____ Step-Father_____
Mother_____ Step-Mother_____

Do you have sole guardianship of the client?_____

***NOTE: If there is split guardianship, we will need legal paperwork stating that one parent is responsible for all child healthcare decisions OR written permission from both parents stating we can evaluate the client.*

II. PURPOSE OF THIS EVALUATION

What questions are to be answered by this evaluation? _____

_____

_____

This client's strengths include:_____

_____

This client's main problems are:_____

_____

What are the teacher's concerns:_____

_____

Does the client have any difficult to manage behaviors?_____

_____

Does the client have any behavior that you consider unique or different compared to most children you know?_____

_____

III. DEVELOPMENTAL HISTORY

A. Was this client adopted?_____ If yes, age at time of adoption_____
Date of adoption_____ Location of adoption_____

B. Mother's medical history during pregnancy:

1. Was this pregnancy a result of IVF?_____
2. Were there any difficulties during pregnancy?_____ If so, please describe:

_____

_____

_____

3. Were there any medications taken during the pregnancy?_____ If so, what kind?_____
4. Where there any accidents during the pregnancy?_____ If so, please describe:_____
5. Were there any emotional pressures during the pregnancy?_____ If so,

please describe:_____

_____

IV. EARLY HISTORY FOR THIS CLIENT

1. Where was this client born?_____
2. Length of pregnancy_____ Length of labor_____
3. Were there any difficulties during labor or deliver?_____ If so, what kind?

_____

_____

4. Was delivery by Cesarean section?_____
5. Weight at birth_____lbs._____oz.
6. Was the client healthy at birth?_____ If not, please describe: _____

_____

_____

7. Did the client require a stay in the NICU?_____ If so, for how long?_____
8. Was the client contented or fretful as an infant?_____
9. Did the infant experience any difficulty establishing sleeping or eating habits?___

_____

10. Were any medications prescribed in the first year?_____ If so, what was prescribed and why?_____
11. Was the client involved in speech-language therapy and/or OT/PT during the first few years of life?_____ If so, why?_____

_____

V. DEVELOPMENTAL HISTORY

When did the client reach the following milestones?

Crept or crawled?_____

Walked unattended?_____

First words spoken?_____

Talked in short sentences?_____

Talked clearly enough that strangers understood?_____

Became toilet trained (easily/difficult)?_____

Learned to skip?_____

Began bicycle riding without training wheels?_____

VI. Medical History

1. Has the client had any serious illnesses?_____ Did this require hospitalization?_____
2. Did the client have a history of ear infections?_____ If so, at what age(s)?_____
3. Is there a history of seizures?_____
4. Is there a history of head injuries?_____ Concussion?_____ If so, when?)_____
5. Is there a history of allergies?_____
6. Please describe any other medical conditions: _____

   _____
7. Describe any serious accidents the client has had:_____

   _____
8. Who is the client's primary physician?_____
9. When was the client's last physical examination?_____

   What were the results?_____
10. Is the client prescribed any medication?_____ If so, what is prescribed and what dosage?_____

    _____

    Have there been any other medications taken the last twelve months?_____

    If so, what prescription and dosage?_____
11. Hearing has/has not been checked: at school/Dr.'s office/Audiologist. Date:_____

    Results: adequate/inadequate. If inadequate, please explain_____

    _____
12. Vision has/has not been checked:

    at school/Dr.'s office/ophthalmologist/optometrist. Date_____

Results: adequate/inadequate. If inadequate, please explain_____

_____

13. Is this client on a special diet?_____ If so, what kind?_____

VII. FAMILY HISTORY

1. List by name the members of this client's family. Please include parents, full, and half siblings.

Name of Family Member	Relationship to this client	Age	Highest Year of School Completed	Reading, Writing, Math, Speech/Language or attention problems? If so, which and when?

2. Please note a history of the following difficulties in both immediate or extended family.

Illness/Difficulty	Check if Yes	When Occurred	Relationship to Client (e.g., maternal aunt)
Hospitalization for Emotional Problems			
Bi-Polar Disorder			
Schizophrenia			
Intellectual Disability			
Drug Addiction			
Criminal Record			
Depression			

Anxiety			
Speech or Articulation Difficulty			
Reading, Writing, Spelling Problems			
Attention Problems or Hyperactivity			
Autism Spectrum Disorder (Asperger's Syndrome), PDD, NOS			

VIII. SCHOOL HISTORY

1. Did the client attend a preschool program?_____ If so, where?_____
   What ages?_____
2. List the names of schools attended beginning with kindergarten:

School Name	Client's Ages	Grade	City/State	School System (public/private)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. Was entry into first grade delayed by attending a primer class or Kindergarten twice?_____
4. Please provide information about current school placement:
   a. Has the teacher reported any concerns?_____
      _____

b. The client's best subjects are:_____

c. Does the client have any specific difficulties in school?_____
   If so, what?_____

d. What are the most recent grades?_____
   _____

e. Does the client have difficulty with the following:
   Finishing his/her work in class?_____
   Staying in his/her seat when asked?_____
   Working independently?_____

f. Describe the homework process_____
   _____
   _____

g. Does the client like school?_____

h. What does the teacher think about the client's behavior? (general attitude, response when corrected, relationships with classmates, etc.)_____
   _____

i. Has the client received speech therapy and/or OT/PT during the school years?_____ If so, for how long?_____

j. Is the client receiving any support in the school (504, IEP, Gifted)?_____
   If so, describe the services offered (speech therapy, occupational therapy, resource room, etc.)_____
   _____
   _____

k. Is the client served under Response To Intervention?_____

l. Is the client currently being tutored?_____

m. Has the client had testing before? If so, by whom and what were the conclusions?_____
   _____

Current teacher's First name: _____ Last Name: _____

Email: _____(a questionnaire will be emailed to your child's teacher; any current teacher will be sufficient)

IX. BEHAVIOR

1. Describe the client's sleep habits._____

   _____

2. Does the client have a history of nightmares or night terrors?_____
3. Describe the client's eating habits._____

   _____

   _____

4. Does the client have difficulty with: What Age(s)

Being bullied	_____
Bullying others	_____
Shyness	_____
Hair twisting/pulling out hair	_____
Thumb sucking	_____
Nail biting	_____
Clumsiness, trouble with gross motor skills	_____
Tying shoes, cutting, catching a ball	_____
Excessive demands	_____
Peer relationships/social skills	_____
Excessively focused on specific interests	_____
Fear of darkness	_____
Restlessness	_____
Daydreaming	_____
Truancy	_____
Fighting	_____
Temper Tantrums	_____
Resenting discipline	_____
Eating issues	_____

Sensitivity to textures _____

Other (please describe) _____

5. Has this client ever had contact with the police or juvenile authorities? _____
   If so, please explain._____
6. Have you or a teacher or pediatrician ever been concerned about an autism spectrum disorder?_____
7. Please describe any unusual behavior patterns your child possesses either positive or negative. _____

   _____
8. Is the client easy or difficult to manage?_____ Do parents agree?_____
9. Does he/she have regular chores?_____
10. What activities does the family do together?_____

    _____
11. Describe how the client gets along with:

    Father_____

    Mother_____

    Brothers_____

    Sisters_____

    Step-Family members in the home_____
12. The client seems to get most upset when_____
13. The client seems happiest when_____

X. SOCIAL INTERACTION

1. This client has (many, average, few, no) friends._____
2. In social activities, this child most often prefers the company of others (younger, older, his/her own age). _____
3. If he/she could, he/she would like to have (many, few) friends; do things (alone, with just one friend, in a group)_____
4. This child likes best to socialize (at home, at someone else's house)._____

5. Please select any behaviors that are observed in this client

_____appears uninterested or does not ask about opinions, comment, thoughts or perspective of others?

_____has poor eye contact during conversations or play?

_____seems unaware of the “unwritten rules” of social play?

_____has a very serious or pedantic way of talking, like a college professor or a “walking dictionary?”

_____speaks loudly or has an unusual cadence or tone of voice?

_____does not understand jokes or figures of speech, or interprets too literally (i.e. Kick the Bucket)

_____seems fascinated and/or very knowledgeable about particular subjects (i.e. Thomas the Tank Engine, Dinosaurs, Pokemon, YugiOh cards, Star Wars, etc.)?

_____becomes upset by changes in routine, or requires much reassurance if things change or go wrong?

_____lines up objects or has rituals or routines that must be followed precisely?

_____acts like he/she is not hearing but can be very sensitive to certain common sounds (puts hands over ears when appliances are turned on)?

_____difficulty with or lack of interest in maintaining friendships?

_____has sensitivities to textures or specific food items?

_____stares at lights, fans, or looks at objects at odd angles?

_____odd motor mannerisms? (hand flicking, head banging, turning objects)

6. What does he/she like to do for recreation?_____

_____

7. Please list any extracurricular activities that the client participates in._____

_____

8. What plans do you have for changes in areas such as family, school, social, medical, etc. that have not been mentioned elsewhere in this questionnaire?

_____

_____

_____

XI. OTHER SPECIALISTS CONSULTED

1. Name_____ Date_____

   Findings_____

   _____

2. Name_____ Date_____

   Findings_____

   _____

3. Please add any additional information you feel will be helpful to us.

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PLEASE INCLUDE COPIES OF ALL PREVIOUS EVALUATION REPORTS, COPIES OF ANY STANDARDIZED TESTING (STARR, SAT/ACT, ETC) AND ANY 504 OR SPECIAL EDUCATION PAPERWORK