|  |
| --- |
| **Learning Support Team**  Parent/Carer Questionnaire |
|  |
| |  | | --- | | Pupil Name: | | Date of Birth: | | Name of person completing this form: | | Relationship to pupil: |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Developmental History**  *It is useful to have an overview of your child’s early life and development.* | | | | | |  | | | **Yes** | **No** | | **Were there any difficulties during pregnancy?** | | |  |  | | **Was the pregnancy full term?** | | |  |  | | **Was delivery/birthing normal?** | | |  |  | | Further details/comments: | | | | | | **At what age did your child** | | | | | | Sit up: | Crawl: | Walk: | | | | If your child did not crawl, please indicate how they moved around: | | | | | | **At what age did your child begin to use a few words?** | | | | | |  | | | **Yes** | **No** | | **Was your child understandable by people (other than family) by the age of 3?** | | |  |  | | **Did or does your child mispronounce words?** | | |  |  | | **Did or does your child have difficulties with clarity of speech?** | | |  |  |  |  |  |  | | --- | --- | --- | | **Hearing** | | | | **Did or does your child have any difficulty with hearing?** | Yes | No | | If yes, please provide details | | | | **Is there a history of ear infections, glue ear or grommets?** | Yes | No | | lf yes, please provide further details: | | |  |  |  |  | | --- | --- | --- | | **Medical Information** | | | | Does your child have any underlying medical conditions?  e.g. epilepsy, cerebral palsy | Yes | No | | If yes, please give details: | | | | **Is your child on any regular medication that may be relevant?** | Yes | No | | If yes, please give details: | | |  |  |  |  | | --- | --- | --- | | **Have any family members experienced difficulties with spelling / reading / learning OR have a diagnosis of dyslexia?** | Yes | No | | If yes, please indicate relationship to child and describe the difficulties: | | | | Is English the child’s first language? | Yes | No | | If no, please answer the following: | | | | Language spoken at home? | | | | Length of time in the UK or English speaking country | | | | Does the child experience difficulties with literacy in their  first language? If yes, please provide details: | Yes | No |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Visual Difficulties** | | | | | | | |  | | Never | Rarely | Sometimes | Often | Always | | 1 | Does your child report headaches when they are reading? |  |  |  |  |  | | 2 | Does your child report that reading makes their eyes feel sore, gritty or watery? |  |  |  |  |  | | 3 | Does your child report feeling tired or sleepy during or after reading? |  |  |  |  |  | | 4 | Have you noticed your child become restless, fidgety or distracted when reading? |  |  |  |  |  | | 5 | Have you noticed your child rubbing their eyes when they are reading? |  |  |  |  |  | | 6 | Have you noticed your child screwing up their eyes when reading? |  |  |  |  |  | | 7 | Have you noticed your child tilting their head to one side when reading? |  |  |  |  |  | | 8 | Have you noticed your child moving their eyes around or blinking frequently when they are reading? |  |  |  |  |  | | 9 | Have you noticed your child holding paper or a book very close to their eyes? ?when reading? |  |  |  |  |  | | 10 | How often does your child use a marker or their finger to keep their place when reading? |  |  |  |  |  | | 11 | Have you noticed that your child frequently loses their place when reading? |  |  |  |  |  | | 12 | Have you noticed your child covering or closing one eye when reading? |  |  |  |  |  |   If, having answered the questions above, you suspect there are visual difficulties\* you **MUST** have your child’s eyesight tested, and discuss the above at the eye test with the Optician (Optometrist), **prior** to the Learning Support Team assessment.  *\*Visual difficulties should be investigated if you answered ‘always’ or ‘sometimes’ to several questions.* |

|  |  |
| --- | --- |
| **Questions on eye and vision history** | **Comments** |
| 1. Has your child any history of visual difficulties / problems with sight / visual impairment? |  |
| 2. When did you last have a sight-test by an optometrist (“optician”)? |  |
| 3. Was any prescription made? **YES / NO**  If **YES**, was your child advised to wear the prescription glasses/ contact lenses for :  distance (e.g. for watching television) or near (e.g. for reading) or both?  If **YES**, does your child wear the prescribed glasses / contact lenses? **YES / NO** (Prescribed glasses/contact lenses should be worn for a SpLD assessment, unless intended for distance use only).  If **NO**, why not? |  |
| 4. Has your child ever used coloured overlays / colour-tinted glasses? If **YES/ NO**  Who advised and provided them?    Why were they recommended? Did they help?  If **YES**, in what way?  Does your child still use them? If not, why not? |  |

**Areas of difficulty for your child (please tick all that apply)**

|  |  |
| --- | --- |
| Difficulty with phonological awareness |  |
| Difficulty following instructions |  |
| Difficulty in finding the right word to describe things |  |
| Mispronounces words |  |
| Needs additional time to produce an oral response |  |
| Responds to social interaction but does not initiate it |  |
| Difficulty understanding jokes/figures of speech |  |
| Listens well but still seems unable to understand |  |
| Slow or struggles to respond when given an instruction or asked a question |  |
| Difficulties understanding non-literal language |  |
| Might respond to just part of an instruction, usually the beginning or end |  |
| Difficulty learning and using new words |  |
| Knows a word but can't remember it or says a word that's similar |  |
| Difficulty making longer sentences |  |
| Sentences sound muddled or confused |  |
| Pauses a lot while talking or restarts sentences |  |
| Finds it hard to understand and make up stories |  |
| Difficulty joining in and keeping up with conversations |  |
| Delayed acquisition of speech and language |  |
| Loses track of what they are saying mid sentence |  |
| Difficulty speaking when asked to explain inappropriate behaviours |  |
| Lack of fluency in reading |  |
| Inaccurate word decoding |  |
| Difficulty with reading comprehension |  |
| Lack of enjoyment of reading |  |
| Persistent and marked difficulty with spelling |  |
| Takes longer than average to complete written tasks |  |
| Difficulty copying from the board |  |
| Written work doesn't reflect verbal ability |  |
| Problems with counting |  |
| Confusion with number direction, e.g. 92 or 29 |  |
| Difficulty remembering how numbers are written |  |
| Difficulties understanding mathematical symbols |  |
| Difficulties with the concept of space |  |
| Takes a long time to complete mathematical tasks |  |
| Problems with estimating |  |
| Problems with the planning of activities |  |
| Poor memory for basic maths facts |  |
| High levels of debilitating anxiety related to maths |  |
| Problems with orientation/direction |  |
| Mixes up similar looking numbers |  |
| A poor understanding of place value and its use in calculations |  |
| Problems remembering shapes |  |
| Problems counting backwards |  |
| Poor concept of time and reading analogue clocks/watches |  |
| Inability to subitise (instantly recognise number of items without counting) |  |
| Persistent difficulties dressing |  |
| Bumps into things/people |  |
| Difficulties running, hopping, jumping, riding a bicycle |  |
| Handwriting difficulties |  |
| Difficulty using scissors, cutlery, etc. |  |
| Poor at ball skills and general co-ordination |  |
| Often good with practical tasks |  |
| Poor stamina |  |
| Often late in reaching milestones; some do not crawl |  |
| Poor posture/hypermobility |  |
| Stiff body posture, possibly lack of sensitivity /numbing in parts of the body |  |
| Has obvious good/bad days |  |
| Low self esteem |  |
| Unaware of external dangers |  |
| Classwork rarely finished |  |
| Attention difficulties |  |
| Sensory issues (e.g. problems with unexpected noise, certain materials, textures) |  |
| Not seeming to listen when spoken to directly |  |
| Easily distracted by extraneous stimuli |  |
| Forgetful in daily activities |  |
| Loses things and is disorganised |  |
| Cannot sit still when expected or required |  |
| Blurts outs answers before the question is finished |  |
| Difficulty in engaging in activities quietly |  |
| Inability to control emotions |  |
| Difficulty reading social interactions |  |
| Difficulty maintaining friendships |  |
| Resistant to change |  |
| Difficulty in transferring skills from one area to another |  |
| Engages in the same task repeatedly and/or in ritual behaviours |  |
| Experiences anxiety and heightened behaviours in new situations |  |
| Difficulty joining in and following games |  |
| Poor behaviour due to communication frustration |  |
| Talks at speed |  |
| Interrupts or intrudes on others |  |
| Has unusual movement patterns |  |
| Makes honest but inappropriate observations |  |
| Socially inappropriate eye contact |  |
| Abnormal use of tone/pitch in speech |  |
| Is hyperactive/uncooperative/oppositional |  |
| Lack of awareness of personal space |  |
| Hypervigilant and aware of changes in environment |  |
| Easily startled by unexpected noises or interactions |  |
| Runs, fights or hides when something goes wrong |  |
| Can suddenly change in mood or demeanor |  |
| Poor short term and/or working memory |  |
| Takes longer to process information |  |
| Difficulty in organising tasks or activities or knowing where to start |  |
| Understanding may be limited to the 'here and now' |  |
| “On the go” constantly |  |
| Appears inattentive/day dreamer |  |
| Finds it hard to take turns |  |
| Difficulty sustaining attention in tasks |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Educational History** | | | |
| **Did your child pass the Phonics Test?** | Yes | No | Unavailable |
| If yes was that at the end of year one or year two? | | | |
| **Has your child’s schooling been disrupted in any way?** | | Yes | No |
| If yes please provide more information: | | | |

|  |
| --- |
| **Literacy** |
| **Please describe your child’s current strengths and difficulties with Literacy?** |

|  |  |  |
| --- | --- | --- |
| **Does the pupil have difficulty recalling the alphabet or other known sequences**  **(e.g. days of the week, months of the year)?** | Yes | No |
| If yes please give details: | | |

|  |
| --- |
| **Numeracy** |
| **Please describe the pupil’s current strengths and difficulties with Numeracy?**  E.g. Any difficulties with: recalling procedures for problem solving; organising the layout of work; recalling number facts?  Do they find any particular equipment useful (e.g. counters, Numicon, visual prompts)? |

|  |  |  |
| --- | --- | --- |
| **Memory, Attention and Concentration** | | |
| **Does your child have difficulties with memory, attention and concentration?** | Yes | No |
| If yes, please provide further details: | | |

|  |  |  |
| --- | --- | --- |
| **Speech, Language and Communication** | | |
| **Are there any difficulties with speech, language or communication?** | Yes | No |
| If yes, please provide further details:  E.g. difficulty with: producing and using speech, language comprehension, articulating ideas | | |
| **Does the pupil have difficulties with social skills, social interaction, behaviour, relationships or emotions?** | Yes | No |
| If yes, please provide further details: | | |
| **Does the pupil have difficulties with self-esteem and confidence?** | Yes | No |
| If yes, please provide further details: | | |

|  |  |  |
| --- | --- | --- |
| **Organisational Skills** | | |
| **Does the pupil have good organisational skills?**  (e.g. remembering homework, equipment or kit, daily routines or timetables, layout of work) | Yes | No |
| If no, please provide further details: | | |

|  |  |  |
| --- | --- | --- |
| **Fine and Gross Motor Skills** | | |
| **Does the pupil have any difficulties with fine and gross motor skills**  e.g. body awareness, movement and balance, pencil control and handwriting, scissor skills | Yes | No |
| If yes, please provide further details: | | |
| **Does the pupil experience difficulties with orientation and/or directional confusion?**  e.g. left/right, letter/number reversals, placing writing on lines appropriately within margins and/or numbers within squares | Yes | No |
| If yes, please provide further details: | | |

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

|  |
| --- |
| **Does your child receive extra tuition outside of school?** |
| Yes No |
| Details: |

|  |
| --- |
| **Has your child ever had any input/support from any other professionals e.g. Educational Psychologist, Speech and Language Therapy, Occupational Therapist? ⎕ YES ⎕ NO**  *(If yes please give details and provide copies reports)* |

|  |
| --- |
| **Any Other Information** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** |  | **Print name:** |  |
| **Relationship to pupil:** |  | **Dated:** |  |