



FORM II: PARENT QUESTIONNAIRE

Child's Name _____ Birthdate _____ Age _____
(first name) (last name) (m/d/year)

Name of Person Completing this form _____

Relation to child _____

1. What are you looking for from educational therapy?
2. Describe your child's experience at school. Do they have a favourite subject? What parts of school do they enjoy the least?
3. What do you see as your child's strengths?
4. What particular things is your child interested in? (particular sport, drawing, imaginative play, etc.)

11. Has your child, or anyone in their immediate family been identified as gifted or skipped a grade?

12. Describe any notable circumstances surrounding your child's delivery and health at birth.

13. Has your child experienced any serious illnesses or accidents? (ear infections, high fever, head injuries) If so, please explain severity.

14. Describe your child's sleep patterns. (rises early, trouble falling/staying asleep, frequently tired)

15. Describe your child's diet. (Food restrictions or avoidances, daily schedule)

16. Date of last hearing exam _____
Results

17. Date of last vision exam _____

Results - visual acuity

- Binocular focus
- Visual processing (amblyopia)

18. List and describe any other testing or evaluations your child has experienced.

Please attach most recent

- Report card
- IEP if applicable
- Other assessments/diagnostic reports

19. List and describe any supports your child has received outside of school and regular home support.
(other therapies, tutoring, etc.)

20. Please feel free to expand on or add anything else you think would be helpful for me to know about your child.

THANK YOU FOR YOUR TIME IN HELPING ME GET TO KNOW YOUR CHILD