

Assessment services

Parent/carer questionnaire



This form is for completion by parents/guardians/carers of children referred for educational assessments to assist in gathering relevant background information. This information is important in assisting with planning the most appropriate assessment and with the interpretation of the results.

Child details

Surname:		First names:	
Date of birth:		Age:	
Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other	Pronouns:	
Country of birth:		Aboriginal or Torres Strait Islander:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Language(s) spoken:		Interpreter required:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Address:			
Sibling names, genders & ages:			

Parent/carer details

Parent/carer 1

Name:		Relationship to child:	
Age:		Occupation:	
Country of birth:		Aboriginal or Torres Strait Islander:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Language(s) spoken:		Interpreter required:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Address:			
Contact Number/s:		Email:	

Parent/carer 2

Name:		Relationship to child:	
Age:		Occupation:	
Country of birth:		Aboriginal or Torres Strait Islander:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Language(s) spoken:		Interpreter required:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Address:			
Contact Number/s:		Email:	

Child's school information

School attended:	
Year level:	
Past school/s & year/s attended:	

Consent for assessment

*This section must be completed in order for assessment to proceed.

Are both parents and/or legal guardians aware of and consenting to the assessment:	<input type="checkbox"/> Yes <input type="checkbox"/> No If 'No' please contact us for a discussion prior to your appointment.		
Name:			
Signature:		Date:	

Reason for referral

Do you have concerns regarding your child's:	<input type="checkbox"/> Learning <input type="checkbox"/> Reading <input type="checkbox"/> Writing <input type="checkbox"/> Mathematics <input type="checkbox"/> Development	<input type="checkbox"/> Social Skills <input type="checkbox"/> Behaviour <input type="checkbox"/> Attention <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Impulsivity
When did you first notice your child's difficulties in each area of concern?		
Has a teacher, paediatrician or allied health professional suggested you seek assessment for any specific diagnoses? If so, which ones:		

Type of assessment requested

<input type="checkbox"/> Cognitive / Psychoeducational Assessment (this includes assessments for investigation of intellectual disability or specific learning difficulties, e.g. dyslexia)
<input type="checkbox"/> ADHD Diagnostic Assessment (please also complete the Comprehensive Background Form)
<input type="checkbox"/> Autism Diagnostic Assessment (please also complete the Comprehensive Background Form)
<input type="checkbox"/> Comprehensive Developmental Assessment (for children under 8 years old) (please also complete the Comprehensive Background Form)
<input type="checkbox"/> Other/I'm not sure - please provide details:

Developmental history

Pregnancy and birth

Birth weight:		Hospital:	
Premature / term / overdue:		Type of delivery (e.g. natural, forceps, caesarean)	
Medication / cigarettes / alcohol during pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify:		
Complications / problems identified during pregnancy or birth:			

Developmental milestones

First sat at:	
First crawled at:	
First walked at:	

Spoke first word at:	
Put two words together at:	
Spoke in sentences at:	
Toilet trained (daytime) at:	
Dry at night at:	
Handedness:	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Mix Handedness

Family history

<p>Are there difficulties with:</p> <ul style="list-style-type: none"> • learning (e.g., dyslexia), • development (e.g., autism, ADHD, intellectual disability), • mental health (e.g., depression, anxiety) present in the immediate or extended family? <p>If so, please detail these:</p>	
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Medical information

Existing medical, developmental, or mental health diagnoses:	
Current medication:	
Medical history including any significant past illnesses or injuries:	
Has the child's vision been checked?	<input type="checkbox"/> Yes <input type="checkbox"/> No Any issues identified:

Has the child's hearing been checked?	<input type="checkbox"/> Yes <input type="checkbox"/> No Any issues identified:
Please describe any concerns regarding eating, sleeping etc.:	

Schooling

Please describe your child's academic skills, including areas of strength and areas of concern:	
Please provide details of current/previous school supports (e.g. ESO support, small group literacy or numeracy programs):	
Concerns reported from school:	

Social and emotional functioning

What are your child's strengths, interests, and hobbies?	
Please describe your child's social and communication skills:	

Assessment services

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Please provide any other information that would be helpful to support this assessment:	
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Previous assessments and interventions

Please provide any existing assessment or intervention reports if available.

Type	Date	Outcomes

Respondent details

Name:			
Relationship to child:			
Signature:		Date:	

Thank you for completing the questionnaire. The information you have provided will assist greatly with this student / child's assessment.

When completed please e-mail to info@solasta.net.au or fax to **(08) 7160 1999**