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| **Learning Support Team**Parent/Carer Questionnaire |
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| Pupil Name: |
| Date of Birth: |
| Name of person completing this form: |
| Relationship to pupil: |
| Previous school(s) attended: |

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| **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?** |  |  |

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| **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: |

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| **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:  |

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| **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 |

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| **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.* |

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| **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)**

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| 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 |  |

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| **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:  |

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

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| **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:  |

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| **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)?  |

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

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| **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:  |

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| **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:  |

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| **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:  |

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

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

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| **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)* |

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| **Any Other Information** |
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| **Signed:**  |  | **Print name:** |  |
| **Relationship to pupil:** |  | **Dated:** |  |