

Suggested Questions for Parent Input for Initial Evaluation

Student's Name: _____ Parent/Guardian Name: _____

Method of Interview (Check one): ☐ Personal Interview ☐ Telephone ☐ Written

Person who collected input: _____ Date: _____

1. What are some of your child's strengths, interests and/or favorite activities?

2. What does s/he like best about school? _____
least? _____

3. If your child has homework, does s/he complete it without help? ☐ Yes ☐ No
If no, what type of help is given?

4. What goals do you have for your child for this school year? For older students, long range goals/plans?

5. Do you have any concerns about your child's progress? ☐ Yes ☐ No
If yes, what are they and when did you first notice these concerns?

6. Have you seen any recent changes in your child's behavior or school performance? ☐ Yes ☐ No
If yes, please explain:

7. Medical information:

- Vision concerns? _____
 - Wears glasses? ☐ Yes ☐ No
- Hearing concerns? _____
 - Wears hearing aid(s)? ☐ Yes ☐ No
- Any other medical/health concerns?

- Medical history: accidents, injuries, surgeries? _____
- Taking medication (Type, reason, side effects)?

- Any psychological (thinking/emotional) concerns?

8. Has your child had a psychological or education evaluation from outside of the school? ☐ Yes ☐ No
If yes, who did it, when was it done, and what were the results?

9. Has your child had additional community services in the last 3 years (tutoring, counseling, residential care)?
☐ Yes ☐ No If yes, please describe:

10. Home life:

- With whom does your child live at home? _____
- What language is spoken at home? _____
- How well does your child sleep at night? _____
 - Length of time sleeping? _____
- Does your child have a good appetite? _____
 - Eats a variety of foods? _____

11. Have there been any significant changes in your home or family relationships recently?

☐ Yes ☐ No If yes, please describe:

12. Optional Functional Questions—Younger students

a. Communication skills at home: Understands directions? Communicates needs? Converses?

b. Types of chores or responsibilities at home?

c. Self care skills: (Bathing, brushing teeth, toileting, etc.)

d. Behavior in the community: (Behavior in public places, can get to places nearby, orders meals, etc.)

e. Follows safety rules at home and in the community (walking, riding bike).

f. Leisure: Shares, has friends

Optional Functional Questions—Older students

a. Communication skills at home: Understands directions? Communicates needs? Converses?

b. Types of chores or responsibilities at home?

c. Behavior in the community: Can get to places independently? Shops independently? Knowledge about places in the community like banks, post offices, gas stations, grocery stores, clothing stores? Other?

d. Follows safety rules and home and in the community (walking, riding, driving)? Self-care for minor injuries?

e. Leisure: Has friends? Participates in school or community activities?

13. Do you have any suggestions for improving the school services being given to your child? ☐ Yes ☐ No

If yes, what are they?

14. Is there any other information about your child that you think may be helpful to your child's evaluation?

☐ Yes ☐ No If yes, what? _____