



**Testing Questionnaire for Parents  
(EXTENDED TESTING)**

**Child:** \_\_\_\_\_

**Birth date:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Parents:** \_\_\_\_\_

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**Family**

Please list all household members.

Adults: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Siblings: \_\_\_\_\_ Age: \_\_\_\_\_  
\_\_\_\_\_ Age: \_\_\_\_\_  
\_\_\_\_\_ Age: \_\_\_\_\_  
\_\_\_\_\_ Age: \_\_\_\_\_

**Early Development**

Was there anything difficult or unusual about your child's prenatal development?

\_\_\_\_\_ yes / \_\_\_\_\_ no

Were there any complications at birth?

\_\_\_\_\_ yes / \_\_\_\_\_ no

If yes to either of the above, please elaborate:

**Speech and Language Development**

Describe how well your child does the following regarding his/her speech in English.

	<i>Well</i>	<i>Adequately</i>	<i>Poorly</i>
Understand what others are saying	_____	_____	_____
Communicate to others	_____	_____	_____
Is understood by others	_____	_____	_____

## **Physical health**

Date of last physical exam: \_\_\_\_\_

Any problems noted? \_\_\_\_\_ yes / \_\_\_\_\_ no

Date of last vision screening: \_\_\_\_\_

Any problems noted? \_\_\_\_\_ yes / \_\_\_\_\_ no

Date of last hearing screening: \_\_\_\_\_

Any problems noted? \_\_\_\_\_ yes / \_\_\_\_\_ no

Does your child have any ongoing medical problems/concerns, including asthma, allergies?

\_\_\_\_\_ yes / \_\_\_\_\_ no

Is child taking any medication (prescription, over-the-counter, etc)?

\_\_\_\_\_ yes / \_\_\_\_\_ no

Has your child experienced any major accidents? Major/ongoing illness? Hospitalization?

\_\_\_\_\_ yes / \_\_\_\_\_ no

Have you noticed your child having any large movement difficulties (walking, running, etc)?

\_\_\_\_\_ yes / \_\_\_\_\_ no

Any small movement difficulties (writing, tying shoes, etc.)?

\_\_\_\_\_ yes / \_\_\_\_\_ no

If yes to any of the above, please elaborate:

## **Social/Emotional health**

What activities does your child participate in at school?

Outside of school?

Do you have any concerns about your child's behavior/emotional health?

\_\_\_\_\_ yes / \_\_\_\_\_ no

If yes, please elaborate:

Does your child adjust with ease to new situations or do they take their time adjusting to new situations?

Please describe to the extent that you feel comfortable any unusually stressful situations your child has experienced and his/her age at the time.

**School history**

Has your child ever been:

- promoted (skipped grade) \_\_\_\_\_ yes / \_\_\_\_\_ no
- in gifted/honors program \_\_\_\_\_ yes / \_\_\_\_\_ no
- retained \_\_\_\_\_ yes / \_\_\_\_\_ no
- been in a dual-language program \_\_\_\_\_ yes / \_\_\_\_\_ no
- in speech therapy \_\_\_\_\_ yes / \_\_\_\_\_ no
- tested for a learning disability or any other learning difference \_\_\_\_\_ yes / \_\_\_\_\_ no
- received extra help during school day \_\_\_\_\_ yes / \_\_\_\_\_ no
- received tutoring outside of school in area of difficulty \_\_\_\_\_ yes / \_\_\_\_\_ no
- experienced social, emotional, or behavioral difficulties in school \_\_\_\_\_ yes / \_\_\_\_\_ no
- been suspended or denied admission to school \_\_\_\_\_ yes / \_\_\_\_\_ no
- left or changed schools in the middle of a school year \_\_\_\_\_ yes / \_\_\_\_\_ no

If yes to any of above, please elaborate:

Thank you for your help.  
**SHARE Education Services**