SEMH & L

Social and Emotional Mental Health and Learning

Parental Questionnaire

To support further assessment around Literacy Difficulties.

Child's Name: _____

School: _____

Parent Name: _____

Kathy Gardner
Team Lead

Parent Questionnaire

Child Name: _____

Date: _____

School: _____

Parent Name: _____

Information given on this form will be included in your child's report. Please be aware that if there is material that you ***do not*** wish to be shared in the report you indicate this clearly and preferably in writing.

	Yes	**Don't Know**	**No**	**Please add additional information if relevant**
1. Does Dyslexia run in your family?				
2. Were they late in talking?				
3. Did your child have difficulty learning nursery rhymes?				
4. Did/ does your child have difficulty with articulating or pronouncing words? (If yes please state)				
5. Did/ does your child have word finding difficulties or using the correct words? (If yes please state)				
6. Has your child ever received support from the Speech and Language Therapy Service, either in pre-school, in school or out of school? Please give details				
7. Did your child crawl before they walked?				

	Yes	Don't Know	No	Please add additional information if relevant
8. Were they late in walking?				
9. Did they/do they have difficulties getting dressed i.e. shoe laces/buttons?				
10. Do they find catching a ball/hopping, skipping or jumping difficult? Can they ride a bike? Please give details				
11. Are they untidy at home?				
12. Can they tell the time?				
13. Do they get their left and right mixed up?				
14. Has your child ever had support from the Occupational Therapy Service or a Physiotherapist? Please give details				
15. Do they have difficulty paying attention at home/in school?				
16. Do they forget what they have been told to do?				
17. Do you have to repeat instructions several times?				
18. Do they forget what order they have to do things?				
19. Are they happy at school?				
20. Is it a battle to get them to go to school?				

	Yes	Don't Know	No	Please add additional information if relevant
21. Do they get frustrated with homework?				
22. Are they confident?				
23. Are they creative?				
24. Do they get on well with other children?				

What do they enjoy doing at home?

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What do they enjoy doing at school?

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What do they think that are good at?

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What would they like to improve at?

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What opinion do they have of themselves?

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Previous Input from Other Professionals:

Please ensure accompanying visual difficulties screening form is completed and attached

Date of last full sight test: ……

Date of last hearing test: ……

Result: ……..….

Has your child any history of “Glue Ear”, grommets etc Yes / No

…….

Has your child had input from an Educational Psychologist or any other professional? Please give reason for referral, outcome and approximate date

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If you have a copy of a report, please may we see this? If not, may we request a copy? Yes / No

Any other information you would like to share:

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