



BELLAVISTA ASSESSMENT & TRAINING UNIT

A VIEW TO A BRIGHTER FUTURE

PLEASE ATTACH ALL PREVIOUS ASSESSMENT REPORTS

Date of submission: _____ Date of completion: _____

PARENT QUESTIONNAIRE

DETAILS OF APPLICANT (Child you would like assessed)

PERSONAL

Surname	
Full first name	
Date of birth	
ID Number	
Age	
Sex	
Home language	
Religion	
Present medication and dosage	
Street address	
Postal address	

SCHOOL HISTORY

CURRENT SCHOOL

Name of school	
School's telephone number	
Principal name	
Class teacher	
Teacher's telephone number	
Teacher's email address	
Present grade	
Grade's repeated	
Medium of instruction	
Do you us give permission to invite the school to our case conference	
Are you applying for a place in the school, if yes please add grade and year	

SCHOOL ATTENDED

	Name	Month & Year of entry	Child's Age	Month and Year of exit
Crèche				
Nursery School				
Primary School				
High School				

Was your child considered ready for Primary School?

YES	NO

Was a Readiness Assessment conducted?

YES	NO

If your child was considered not ready, what reasons were given?

In which grade was difficulties first noticed?

Comment on the school your child is presently attending. How many children are there in his/her class? Does your child relate well to his/her teacher? Are you happy with the attention he receives?

MEDICAL AID DETAILS

Medical aid	
Membership number	
Medical aid package	
Dependant code	
Medical Aid contact number	

PARENTAL INFORMATION**FATHER**

Full name	
ID Number	
Present occupation	
Nationality	
Name of business	
Business address	
Business telephone number	
Cellphone number	
Home telephone number	
Email Address	
Residential Address	
Postal Address	
Previous occupations over child's lifespan	
Have any of these jobs necessitated long absences from home	

MOTHER

Full name	
ID Number	
Present occupation	
Nationality	
Name of business	
Business address	
Business telephone number	
Cellphone number	
Home telephone number	
Email Address	
Residential Address	
Postal Address	
Previous occupations over child's lifespan	
Have any of these jobs necessitated long absences from home	

MARITAL STATUS

Single	Married	Divorced	Separated	Widowed	Deceased

If separated, to whom must documentation be sent?

Both	Father Only	Mother Only

If divorced, who has legal custody?

Father	Mother

If divorced does the other parent have access and visiting rights

YES	NO

Is this child

Biological	Fostered	Adopted

Siblings (In Chronological Age)

Name	Age	School	Class	Academic progress

Position of child to be assessed, within the family: _____

YOUR CHILD NOW (at home)

(Please tick the correct answer)

Sleep

Restless	Regular	Nightmares	Bedwetting	Sleepwalking

Eating

Good appetite	Fussy eater

Habits

Thumb sucking	Nail biting	Twitching	Other

Can your child concentrate for an extended period of time, eg, playing, watching TV?

Yes	No

Do you have to continually repeat instructions?

Yes	No

Does your child get distracted easily?

Yes	No

How do you rate the following?**Concentration**

Good	Average	Poor

Activity level

Overactive	Normal	Poor

Talks

Too much	Average	Too little

Fidgets

A lot	A little	Not at all

Socially: (at home)

Does he/she prefer to play alone?

Yes	NO

Does he/she like to have the company of friends?

Yes	NO

Does he/she interact well with friends?

Yes	NO

What age group does he/she prefer to play with?

Older	Younger	Both

How does he/she interact with family members?

How does he/she interact with other adults?

PARENTS' EDUCATION**FATHER**

Primary Education	
High School	
Tertiary Education	

MOTHER

Primary Education	
High School	
Tertiary Education	

FAMILY HISTORY

Comment on any factors you feel are significant within the family eg. Physical and health or learning difficulties. Please elaborate where possible.

Did either parent experience concentration difficulties as a child?

Father	Mother

Now, as an adult, do you find it difficult to sustain attention?

Father	Mother

Did either parent experience any kind of learning difficulties at school? Please specify.

Father	Mother

10.

Did either parent or extended family member (brother, cousin, etc) experience a reading or spelling problem?

Father's side	Mother's side

Does anyone in the family have a speech, language and/or hearing problem?

Father's side	Mother's side

Is your child left handed?

Yes	NO

Is any other family member left handed?

Father's side	Mother's side

Has the child or the family ever experienced any trauma eg? Death of a loved one, divorce, hijacking, violence etc? Please give details.

FAMILY RELATIONSHIP:*Please describe the following*

Marital relationship

Relationship of child with father

Relationship of child with mother

Relationship of child with siblings

Other significant role players

DISCIPLINE

Who disciplines at home and how?

Is it consistent?

YES	NO

12.

What discipline problems do you experience with your child?

PREVIOUS ASSESSMENTS

Please state whether your child has had any previous testing (eg. psychological, educational) and if so, by whom and when?

IT IS IMPORTANT FOR THE ASSESSOR TO KNOW WHAT TESTS HAVE BEEN DONE ON YOUR CHILD. SOME MAY NOT BE REPEATED AS THEY REQUIRE A SET PERIOD BEFORE RETESTING MAY OCCUR.

Paediatrician

Name and Surname	
Contact Number	
Reason	
Assessment Date	
Findings	
Medication	

Neurologist

Name and Surname	
Contact Number	
Reason	
Assessment Date	
Findings	
Medication	

Psychologist / Psychiatrist

Name and Surname	
Contact Number	
Email Address	
Reason	
Assessment Date	
Findings	

Occupational Therapist

Name and Surname	
Contact Number	
Email Address	
Reason	
Therapy Date	
Findings	

Speech Therapist

Name and Surname	
Contact Number	
Email Address	
Reason	
Therapy Date	
Findings	

Physiotherapist

Name and Surname	
Contact Number	
Email Address	
Reason	
Therapy Date	
Findings	

Remedial Therapist

Name and Surname	
Contact Number	
Email Address	
Reason	
Therapy Date	
Findings	

School Psychologist Service

Name of School Board	
Contact Number	
Email Address	
Reason	
Therapy Date	
Findings	

THERAPIES

IF YOUR CHILD IS STILL RECEIVING THERAPY, PLEASE ASK THE THERAPIST FOR A RECENT PROGRESS REPORT

PLEASE INCLUDE ALL THE THERAPY YOUR CHILD HAS RECEIVED

Physiotherapist

Name and Surname	
Contact number	
Email Address	
Date commenced	
Date terminated	
Therapy still continuing	
Specific areas addressed	

Occupational Therapist

Name and Surname	
Contact number	
Email Address	
Date commenced	
Date terminated	
Therapy still continuing	
Specific areas addressed	

Speech Therapist

Name and Surname	
Contact number	
Email Address	
Date commenced	
Date terminated	
Therapy still continuing	
Specific areas addressed	

Remedial Therapist

Name and Surname	
Contact number	
Email Address	
Date commenced	
Date terminated	
Therapy still continuing	
Specific areas addressed	

Psychologist

Name and Surname	
Contact number	
Email Address	
Date commenced	
Date terminated	
Therapy still continuing	
Specific areas addressed	

Do you give as permission to invite the above therapist to the Case Conference?
(Please tick below)

Yes	NO

DEVELOPMENTAL HISTORY

PREGNANCY AND BIRTH

Please tick in the appropriate column **and comment**.

PREGNANCY	Yes	No	Comment
1. Were there any miscarriages/still births?			
2. Was your baby planned? How long had you been married when the baby was born?			
3. Did mother have physical and/or emotional problems during pregnancy? eg. flu, infections, unusual tension or trauma? If so, please elaborate.			
4. Were any medications taken during the pregnancy? If yes, what were they?			
5. Were X-rays and scans taken? How many?			
6. Smoked during pregnancy?			
7. Drank during pregnancy?			
BIRTH Please state whether your baby was premature, full term or post-mature			
1. Where was the baby born (name hospital where appropriate)			
2. Was there a prolonged labour?			
3. Was there any foetal distress?			
4. Forceps used?			
5. Cord around neck?			
6. Caesarian section? Why?			
7. Was an incubator used? For how long? Could parents touch baby in the incubator?			
8. What was the Apgar rating? At 1 minute? At 5 minutes?			
9. What was the birth weight?			
10. Were there breathing difficulties? Was oxygen administered?			

	Yes	No	Comment
11. Initial jaundice? (a) Was the baby put under lights? _____ (b) For how long?			
12. Did mother and baby go home together? _____ (a) If not, did mother visit daily? _____ (b) How long did baby remain in hospital?			
13. Did mother breast feed at hospital or express milk to take it into the hospital?			
14. Post natal depression? For how long? Was any treatment necessary? Were there any problems in bonding?			

INFANCY:

	Yes	No	Comment
Did your baby experience :			
1. <u>Feeding problems</u> . Who advised? How many formulas tried? Did you stick rigidly to 4 hour feeding or did you feed on demand?			
2. <u>Colic</u> . Was there excessive crying? Did it last 3 months or was it longer? How did this make you feel?			
3. <u>Disturbed Sleep Patterns</u> .			
4. <u>Excema, Asthma, other allergies</u> .			
5. Did you notice that at times your baby seemed to be floppy or very stiff?			
6. When did you start toilet training?			
7. When was he dry during the day and at night?			

Baby's behaviour

Difficult	Content	Sleepy aggression	Head banging	Temper tantrums	Rocking	Breath holding

EMOTIONAL DEVELOPMENT

	Yes	No	Comment
In his first three years, did your child :			
1. Suck a dummy?			
2. Bite his/her nails?			
3. Suck his/her thumb?			
4. Have a special toy/blanket?			
5. Masturbate heavily? How did you deal with this?			
6. Hair pluck? Where?			
7. Head bang?			
8. Have specific fears? What are they? Is there a realistic origin?			
9. Have nightmares? Does he/she sleep with the light on?			
10. Have tantrums? How do you deal with these?			
11. Bed-wetting problems? Could you say <u>when</u> he wets the bed? In the early hours or later? Is there any thrashing about in bed?			
12. Soiling problems?			

Comment on any of the above habits that still continue

Are these, in your opinion, related to school? If not, what do you think causes this at home?

--

Is your child easily frustrated?

YES	NO

Is he overly sensitive or emotional?

Overly Sensitive	Emotional

MEDICAL HISTORY**PLEASE GIVE THE FOLLOWING DETAILS:**

	NAME	DATE	COMMENTS including changes in behaviour
Childhood illnesses			
Operations			
Allergies			

Has your child had a *thorough medical examination recently by a paediatrician?*

YES	NO

If so, please fill in the following

By Whom	When

What were the findings?

RECORD OF MEDICATION

Year	Type of medication and dosage	Prescribed by	Behavioural changes

Please attach reports for the below testing, failing to do so will result in a delay regarding assessments.

AUDITORY/SOUND
HEARING TEST

By Whom	
Date	
Findings	

Does your child:

	Yes	No	Comment
seem to hear sounds unnoticed by other children/adults?			
seem to be very sensitive to sounds, eg, refrigerator, fluorescent lights, heaters?			
seem confused as to the direction from which a sound comes?			

VISUAL SYSTEM
EYE TEST

By Whom	
Date	
Findings	

Does your child:

	Yes	No	Comment
have a diagnosed visual defect? how has this been treated/corrected?			
wear glasses? If yes, please ensure that they are brought with to the assessments			
seem to have difficulty following a moving object?			
make reversals when copying?			
appear to be sensitive to light/sunlight?			
resist having his/her eyes closed/covered?			
blink his/her eyes continuously?			
are his/her eyes continually red/watery?			
tend to work with his/her head close to the table?			
become excited/confused when confronted by a variety of visual stimuli/objects?			

MOTOR MILESTONES

Approximately when did the following occur?

(If you cannot recall exact ages, did it appear to be the same as other children or earlier or later?)

	Yes	No	Age/Comment
Smile			
hold head up			
roll over			
sit by himself without help			
Crawl in what way? for how long did he/she crawl?			
Walk			
ride a tricycle			
ride a bicycle without Afairy@ wheels			
	Yes	No	Comment
did your child use a walking ring? If yes, at what age did the child start using it at what age did the child stop using it? for how long each day was he/she in it?			
did your child use a jolly jumper?			
does your child enjoy jungle gym equipment and other outdoor activities?			
FUNCTIONAL TASKS :			
does your child dress/undress him/herself?			
does your child experience difficulty with shoelaces or buttons, putting on a T-shirt or sweater?			
is your child a messy eater?			
where does your child eat? at the table, with the family or alone? at what time?			
does your child bath independently? brush teeth independently? use the toilet independently?			

SENSORIMOTOR HISTORY:	Yes	No	Comment
<i>if there have been noteworthy changes or alterations in the following behaviours, please comment on these as this could help the therapist.</i>			
1. Tactile sensation - does your child :			
dislike being touched?			
prefer to touch than to be touched?			
dislike being cuddled/hugged?			
seem irritable when held?			
have a strong need to touch people, objects and/or animals?			
seem easily irritated or enraged when touched by siblings or playmates?			
frequently push/bump other children (eg. when standing in a line)?			
seem to pick fights at school (eg. standing in line, on the playground)?			
isolate him/herself from other children?			
react negatively to the feel of new clothes/labels on collars/textures of clothes?			
seem unaware of excessive temperature (eg. wear a sweater in summer?)			
dislike having hair and/or face washed?			
dislike having a haircut?			
object strongly to having his/her nails cut?			
dislike being dirty or sticky? Will he/she play with clay, mud, etc.?			
avoid taking off his/her shoes and walking barefoot on grass, sand, etc.?			
seem extremely brave or almost unaware of painful experiences, eg, stitches, injections, bruises, cuts?			

	Yes	No	Comment
2. Taste and Smell - does your child :			
identify odours?			
ignore/react strongly to bad smells?			
is your child overly sensitive to different smells?			
refuse to try new foods?			
dislike food or certain textures (eg, rough, food that needs to be chewed, sherbet)			
only eat foods that are smooth with no lumps?			
act as if all foods taste the same?			
explore the environment by tasting/putting everything into his/her mouth?			
refuse to co-operate at the dentist?			
dislike brushing teeth?			
3. Vestibular - does your child :			
enjoy being rocked?			
is/was your child scared when you playfully throw/threw him/her up in the air and catch/caught him/her?			
seem fearful of space, eg, going up and down stairs, escalators, lifts, etc.?			
appear to be clumsy and often bump into things and/or fall down?			
enjoy fast moving, rolling, spinning movements and/or rides?			
tend to avoid balance activities such as climbing over chairs, balance beams?			
avoid jungle gyms and outdoor climbing activities?			
dislike riding on an adult's shoulders?			
get car sick easily?			
are your child's movements slow, plodding and/or deliberate?			

	Yes	No	Comment
4. Co-ordination - does your child :			
seem to be in perpetual motion from the time he/she wakes until bedtime?			
manipulate small objects with his/her fingers?			
seem accident prone, ie, have frequent bumps, bruises, scratches?			
eat in a sloppy manner? _____			
Does he/she use a spoon, knife, fork correctly?			
have difficulty with pencil activities, eg, colouring in, outlining?			
appear to tire easily?			
has your child established a consistent hand dominance? Which hand does he/she prefer?			
seem to ignore one side of the body? Which side?			
appear to have difficulty with tasks requiring a sequence of movements, eg, dressing?			
have noticeable tongue movements when concentrating hard?			
appear to be stronger or weaker than other children of a similar age?			
frequently grasp objects too loosely or too tight			
5. Play - does your child :			
play in a constructive or destructive manner?			
play out of his/her own volition/initiative or does he/she need to be constantly guided/led?			
is he/she organised in his/her approach to an activity/task or does he/she work in a haphazard manner?			
use the toys/equipment appropriately for his/her age?			
when playing, will he/she first attempt the game or will he/she rather watch others before attempting it him/herself?			

SPEECH MILESTONES**Medical History**

Has your child suffered from ear infections?

	Never	Seldom	Frequently
0 – 3 years			
3 – 6 years			
Above 6 years			

When was the last ear infection?

--

By whom was it treated and how?

Whom	How

Is there a family speech problem? Please give full details.

SPEECH AND LANGUAGE MILESTONES:

Did your baby cry at birth?

Yes	No

Was he an abnormally quiet baby? (Not just a contented)

Yes	No

Did your baby respond to sounds?

Yes	No

Was he able to imitate sounds?

Yes	No

Please give approximate dates (eg. 11 months) to the following:

	Dates
Babbling	
First Words	
Sentences	

AT PRESENT:

Does your child show understanding when spoken to?

Yes	No

If yes or no, what makes you certain of this?

How do you rate your child's vocabulary in comparison with others of his age?

When your child speaks

	Yes	No
Does he express himself fluently		
In long sentences		
With a good vocabulary		

Is he easily understood by others?

RELEASE FORM

In order that we can provide you and your child with the maximum assistance, it is important that we have as much information as possible concerning the developmental history of your child. This includes information concerning difficulties experienced by your child as well as results of any medical, psychological or any other professional testing. You are entitled to seek an assessment even if your child is currently in therapy with another therapist.

To obtain reports on the results of any tests, or to forward any information, we require your permission in writing. We assure you that all information on your family and your child will be kept strictly confidential. It is important for the assessor to know what tests have been done on your child as some may not be repeated, or they may require a set period before retesting may occur.

- 1) I hereby authorise the release of any information with regard to _____ (name of pupil) to Bellavista School.
- 2) I hereby authorise Bellavista School to release any information concerning _____ (name of pupil) to any school or professional if deemed necessary.
- 3) I hereby give permission for Bellavista to invite my child's teacher to attend the Case Conference.
- 4) I hereby declare that all the information provided is to the best of my knowledge, accurate and true.
- 5) I agree to pay Bellavista in full on completion of the assessment.

SIGNED: _____ in the capacity of parents or guardian. .

If other, please specify.

DATE: _____

Viv van Staden (Clinical Director) secretarybatu@bellavistaschool.co.za

Governors: M Ber, B Campbell, C Comrie, B Hotz, A Howie, E Lehapa, D Lewis, D Loxton, W Marshall (Chairman), P Sullivan, B Walton
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 Member of the Independent Schools Association of Southern Africa.

PLEASE ENSURE THAT YOUR CHILD IS WEARING HIS/HER GLASSES AND HAS TAKEN THE NECESSARY MEDICATION PRIOR TO THE ASSESSMENT.

PREVIOUS ASSESSMENT REPORTS SHOULD ACCOMPANY THIS QUESTIONNAIRE.

ONLY IN SIGNING THIS FORM YOU GIVE US PERMISSION TO CONTINUE WITH THE PROCESS

Viv van Staden (Clinical Director) secretarybatu@bellavistaschool.co.za

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