SUMMIT CENTER

Reach New Heights

Assessments • Consultation • Counseling

PARENT QUESTIONNAIRE

Re-Evaluation Clients Only

Dear parent,

Please fill out this form as best you can. Having all the facts will help us do the most thorough evaluation and be most helpful to you. If you can't remember something exactly, put an approximate answer with a question mark. Please feel free to use the backs of the pages for extended answers.

Date Completed: _____

Child's Name: _____ Birthdate: _____

Gender: _____ Preferred pronoun: _____ Age: _____

Grade: _____ School: _____

Ethnicity _____

Primary language: _____ Other languages spoken: _____

Child's Handedness (Please circle or check) ☐ Left ☐ Right ☐ Ambidextrous

1) Parent/Guardian: _____ Occupation: _____

Home telephone: _____ Work telephone: _____

Cell: _____ Email: _____

2) Parent/Guardian: _____ Occupation: _____

Home telephone: _____ Work telephone: _____

Cell: _____ Email: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact and Phone Number: _____

Relation to the child: _____

www.summitcenter.us

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Who else did you consult while completing this form?: _____

Relation to the child: _____

Who were you referred by: _____
Why are you seeking a reevaluation?

_____

_____

Current and past diagnoses: _____

_____

What interventions have you tried since the last evaluation:

_____

_____

If you were evaluated by us, which of these recommendations did you implement? (Please check)

- ☐ Developmental optometrist
- ☐ Reading Tutoring
- ☐ Writing Tutoring
- ☐ Other _____
- ☐ Audiologist
- ☐ Math Tutoring
- ☐ Executive Functioning Coaching

Do siblings have any diagnoses?

_____

Does your child have an IEP or 504 plan? If so, what accommodations/services do they receive?

_____

_____

Would you like the teacher to be contacted? _____

If applicable and agreed upon, should their insight be deemed necessary in conducting the evaluation? If so, please include teacher e-mail address. If not, write N/A or reason for exclusion. Teacher e-mail for teacher questionnaires: _____

What are your child's current grades like?

_____

_____

Has your child repeated or skipped any grades?

_____

Does your child currently receive partial acceleration?

_____

Current academic challenges: _____

_____

_____

Current academic strengths: _____

_____

_____

Is there a family history of early educational difficulty? _____

_____

Date and Results of last hearing test: _____

Does your child wear an ear filter or hearing device? Describe: _____

Date and Results of last vision test: _____

Does your child wear glasses? Why? What is the recommended use?

_____

List current medications and associated diagnoses:

_____

_____

Updated medical history: _____

i. Allergies: _____

ii. Food sensitivities: _____

iii. Eating habits, growth: _____

iv. Sleep habits and/or concerns: _____

v. Exercise: _____

Any concerns about your child's language? _____

_____

How would you describe your child's current personality and temperament?

_____

_____

What interventions is the child currently receiving? _____

_____

_____

Counseling/Therapy? _____

_____

Therapist Name: _____ Frequency: _____

General goals for therapy: _____

Are the child's parents ☐ married ☐ divorced since _____ ☐ separated since _____

☐ single ☐ other _____

If the parents are not together, what is the custody agreement? _____

_____

Contact information to reach the non-custodial parent (if needed):

_____

Indicate specifically which parent(s) holds the legal right to authorize and consent to the child's treatment by a mental health practitioner. _____

Indicate which parent(s) have been given rights to access information about the child's treatment and/or evaluation.

_____

If applicable, please include a copy of documentation pertaining to custody and rights to consent to treatment by a mental health practitioner. Please check here if a copy has already been provided. ☐

Who does your child live with? _____

Describe your child's relationship with you. _____

_____

_____

Describe your child's relationship with sibling(s) if applicable.

_____

_____

Discipline methods that have been effective with your child:

_____

_____

Current favorite activities:

_____

_____

Current least favorite activities:

_____

_____

Does your child prefer group or individual activities?

_____

_____

Social strengths/social concerns: _____

_____

Does your child get along with teachers/peers?

_____

_____

Special talents and abilities:

_____

_____

What do you appreciate most about your child?

_____

_____

_____

Is there anything else that you would like to add that has not been covered by this questionnaire?

_____

_____

_____

_____