

Dyslexia Support Consultancy

Sarah-Louise Jeffries

Tel: 0781 806 3634

enquiries@dscsupport.co.uk

www.dyslexiasupportconsultancy.com

Please give as much information as possible.

All information given will be treated confidentially.

Dyslexia Support Consultancy regards personal information as very important and fully adheres to the principles of Data Protection. When you come for an assessment at personal data (including name, date of birth, address) will be collected. This will be retained by DSC, stored securely in line with the Data Protection Act 2018 (GDPR) and not shared. We are totally committed to protecting your information and using it responsibly.

Parental Questionnaire (Confidential)

1. Details

Child's Name	Date of Birth	Gender Male / Female
Name of Parents/Guardians	Address Post Code – Phone number (Home) - Phone number (Mobile) – E-mail address – School – Year Group -	
Relationship to the child		
Is the child adopted?		

2. Birth and Early Development

Were there any unusual features or complications during pregnancy and birth?

* Yes No

Was the pregnancy full term?

Yes *No

Was delivery normal?

Yes *No



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If you have answered any questions above that have a * against them please give details below:-

Were there any unusual features or complications in early childhood?

*Yes No

Were there problems in the early months?

*Sucking *Feeding *Fits *Other

If you have answered any questions above that have a * against them please give details below:-

At what age did your child:-

Sit up	Crawl	Walk without help
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Is your child right or left handed? At what age did they show a preference?

Right Left Age of preference

Has your child had:

Measles	<input type="checkbox"/>	Chickenpox	<input type="checkbox"/>
Glandular Fever	<input type="checkbox"/>	Mumps	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	Other illness	<input type="checkbox"/>

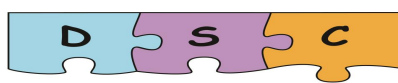
Does your child suffer from any allergies such as eczema, hay-fever, asthma?

*Yes No

If yes please provide details:

Does your child take any regular medication? *Yes No

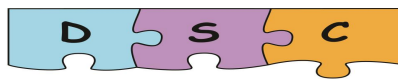
If yes please provide details:



Is your child normally healthy?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Is your child vegetarian?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Is your child on a special diet?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are any foods avoided?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Is your child a fussy eater?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Questions on eye and vision history	Comments and notes
1. Has your child any history of visual difficulties/problems with sight/visual impairment?	
2. When did you have a sight-test by an optometrist (Optician)?	
3. Was any prescription made? Yes/No If YES , was your child advised to wear the prescription glasses/contact lenses for distances (e.g., for watching television) or near or both? If YES , does your child wear the prescribed glasses/contact lenses? If NO , why not?	
4. If YES , does your child wear the prescribed glasses/contact lenses? If NO , why not?	Prescribed glasses/contact lenses should be worn for a SpLD assessment, unless intended for distance use only.
5. If YES , does your child have the prescribed overlays/coloured-tinted glasses? YES/NO , If YES Who advised and provided them? Why were they recommended? Did they help? If YES , in what way? Does your child still use them? If not, why not?	
Question on reading/near work activity?	
6. Approximately how many hours per school day does your child spend at a screen (phone, tablet, computer) etc?	
7. Approximately how many additional hours per school day does your child spend reading books, newspapers, comics, or other paper-based texts?	
8. Has your child's screen/reading/ near work time increased recently? If so, by how much?	

Section for parents/carers**	Never	Rarely	Sometimes	Often	Always
1. Does your child report headaches when they are reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child report that reading makes their eyes feel sore, gritty or watery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child report feeling tired or sleepy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



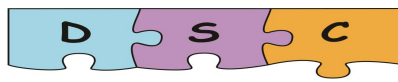
during or after reading?					
4. Have you noticed your child become restless, fidgety or distracted when reading?					
5. Have you noticed that your child rubs their eyes when they are reading?					
6. Have you noticed your child screwing up their eyes when reading?					
7. Have you noticed your child tilting their head to one side when reading?					
8. Have you noticed your child moving their eyes around or blinking frequently when they are reading?					
9. Have you noticed your child holding a paper or book very close to their eyes when reading?					
10. How often does your child use a marker or their finger to keep their place when reading?					
11. Have you noticed that your child frequently loses their place when reading?					
12. Have you noticed your child covering or closing one eye when reading?					

Section for your child

13. When you read, do you see two of each word?					
14. When you read, do the words look blurry (or fuzzy, or unclear)?					
15. When you are reading, do the words move on the page?					
16. When your teacher ask you to copy something from a screen at the front of the classroom, can you see what is written on the screen?					

** N.B. Response Categories for this are: **Always** = every day. **Often** = several times a week but not necessary every day. **Sometimes** = 2-3 times a month. **Rarely** = only once every few months/a year.

When was your child's hearing tested? (What were the results)	
Has your child had ear infections?	
Has your child had grommets inserted?	
Did or has your child suffered from frequent ear, sinus, throat or chest infection?	
If yes please give details:	



3. Family Background

When assessing for Dyslexia it is important to have a comprehensive family background. Are there any family members who have experienced difficulty in learning (please include both parents' families and say which relatives)?:-

Relative:	Speaking	Reading	Writing	Spelling	Maths	Diagnosed ?

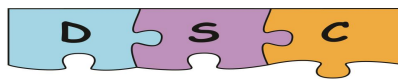
Do any relatives have any diagnosis of ADHD, dyspraxia, dyslexia, hypermobility, etc?
Who are they and what is their relationship to your child?

	Occupation or school	Right /left handed
Mother		
Father		
Brothers/Sisters (ages)		
Other carers involved with your child:		

4. Linguistic History

What languages are spoken at home:	1.
	2.
If English is not your child's first language, how long has English been spoken?	
Does your child experience difficulties in his/her first language and how does this affect them?	

Was your child talking by 18 months of age? Yes *No



Were there any problems with your child's speech and language development? (for example, clarity of speech, understanding spoken language and self-expression).

*Yes No

Does he/she mispronounce words or sounds? *Yes No

If you have answered any questions above that have a * against them please give details below:-

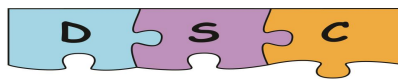
Has your child had a Speech and Language Assessment or therapy? (*Please enclose the report)

Yes No

5. Motor Skills

Does/did your child have difficulty with any of the following:-

	In the past	Ongoing	No
Handwriting			
Cutting out			
Running			
Lego			
Jigsaw puzzles			
Colouring/drawing			
Dressing			
Using Cutlery			
Tying shoelaces			
Catching balls			
Throwing balls			
Climbing stairs			
Cycle riding			
Co-ordination			
Clumsiness			
Remembering nursery rhymes			
Learning times tables			
Organisation			



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Please explain any difficulties noted above:-

Is your child good at sports?

6. School details

Name and address of current school:

Are there any special circumstances relating to school which could have adversely affected your child's progress at school? e.g., interrupted schooling, poor teaching in earlier schools absence through ill health etc.....

Previous schools attended with dates:

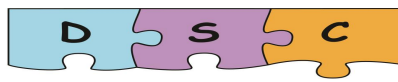
What is your child's attitude towards school?

Has your child had extra support at school? (If yes please describe when, how often and in what subjects)

Has your child had extra tuition outside of school? (If yes please describe when, how often and in what subjects)

Has your child been assessed previously by any other professional, e.g., Specialist Teacher/Occupational Therapist:

(If yes please send a copy of the report with this questionnaire)



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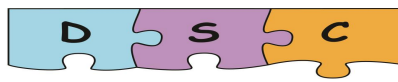
Any other information?

7. Current Situation

Memory, Attention and Concentration – Does your child find it difficult to remember information/instructions, please give as much detail as possible? Do they find it difficult to concentrate?

Speech, Language and Communication Does your child find it easy to locate the words they want to say/write? Any other information?

Organisational skills – Does your child find it difficult to organise themselves and please give examples



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How are your child's social skills? Do they get on well with their peers, siblings, adults within/outside their family? Please describe any difficulties

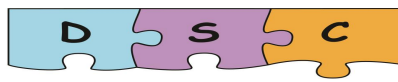
What are your child's strengths?

What are your child's weaknesses?

8. Child's Views

Please ask your child to complete the following questions

What are your favourite subjects at school? Why?



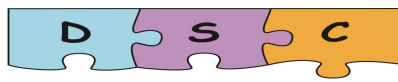
What subjects don't you like at school? Why?

What do you find difficult at school?

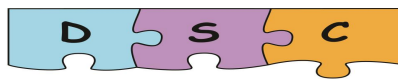
9. Dyscalculia

Please tick yes, no, sometimes or not sure.

Does the Learner:-	1 Not often, 2 Sometimes, 3 Always	Comments
1. Have difficulty counting objects accurately – for example, lacks the ability to make one-to-one correspondence' when counting objects (match the number to the object) or does not organise objects to help monitor counting?		
2. Finds it impossible to 'see' that four randomly arranged objects are 4 without counting (or 3, if a young child)?		
3. Have little sense of estimation for bigger quantities?		
4. Reverse the digits in numbers, for example, writes 51 for fifteen or 45 for fifty-four?		
5. Have difficulty remembering addition facts, which may be revealed by: a. Counting on for addition facts, for example, for 7 +3, counting on 8,9,10 to get the answer. b. Counting all the numbers when adding, as for 7 + 3 again, counts 1,2,3,4,5,6,7,8,9,10?		
6. Not 'see' immediately that 7 + 5 is the same as 5 +7 or that 7 x3 is the same as 3 x 7?		
7. Finds it difficult to progress from using concrete aids (fingers, blocks, tallies) to using only numbers as symbols?		
8. Finds it much harder to count backwards compared to forwards?		



9. Finds it difficult to count fluently less familiar sequences, such as: 1,3,5,7,9,11 Or 14, 24, 34, 44, 54, ...?		
10. Only know the 2x 5x and 10 multiplication facts?		
11. Count on to access the x2 and x5 facts?		
12. Manages to learn other basic multiplication facts, but then forgets them overnight?		
13. Makes 'big' errors for multiplication facts, such as $6 \times 7 = 67$ or $6 \times 7 = 13$		
14. a) fails to 'see' the relationships between addition and subtraction facts? b) fails to 'see' the relationships between multiplication and division facts?		
15. Use lots of tally marks for addition or subtraction problems?		
16. Not group the tallies as in the 'gate' (###) pattern?		
17. Not understand and use place value knowledge when doing addition and subtraction problems?		
18. Finds it difficult to write the numbers which have zeroes within them, such as 'four thousand and twenty one'?		
19. NOT know and understand the underlying place value concept, how to multiply and divide by 10,100, 1000, and above?		
20. Finds it difficult to judge whether an answer is right, or nearly right?		
21. Find estimating impossible for a) Addition b) Subtraction c) Multiplication d) Division?		
22. Forget (these are short-term memory problems) a. The question asked in mental arithmetic b. Instructions (which can cause the learner to be slow to start work in class?)		
23. Struggle with mental arithmetic (which can be a working memory problem)?		
24. 'see' numbers literally and not inter-related, for example, counts from 1 to 9, rather than subtracting 1 away from 10?		
25. Have poor memory skills with money, for example, unable to calculate change from a purchase?		
26. Think an item priced as £4.99 is '£4 and a bit' rather than almost £5?		
27. Prefer to use formulas and procedures (even if difficult to retain in long-term memory) but uses the, mechanically without any understanding of how they work?		
28. Forget mathematical procedures completely or in part, especially as they become more complex, such as 'long' division.		
29. Organise written work poorly, for example does not line up columns or numbers properly?		



30. Not see and pick up new patterns or generalisations especially ones that are new or challenge consistency, for example, $\frac{1}{2}$, $\frac{1}{3}$, $\frac{1}{4}$, $\frac{1}{5}$ is a sequence that is getting smaller?		
31. Enter date into a calculator in the incorrect sequence?		
32. Find clocks and time difficult to read and understand?		
33. Think that algebra is impossible to understand?		
34. Works slowly, for example, attempt less questions than his/her peers?		
35. Get very anxious about doing ANY maths?		
36. Shows reluctance to try any maths, especially unfamiliar topics.		
37. Become impulsive, rather than being analytical, when doing maths and rush to get it over with?		

10. Other information

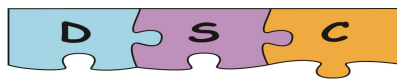
What does your child enjoy doing– favourite activities, hobbies, interests?

Does your child have any particular dislikes?

11. Parental Comments

Why do you want an assessment for your child?

Please detail below any problems you feel your child is experiencing with learning, and what type of support, if any would you like for your child:



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Any other comments:

AUTHORISATION

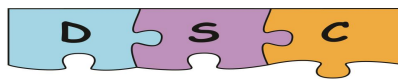
- I/we instruct Dyslexia Support Consultancy to arrange for an assessment to be carried out on my/our child.
- I/we confirm that:
- I/we have received, read and accept Dyslexia Support Consultancy’s Terms and Conditions.
- I/we have explained the reason for the assessment to my/our child
- the information provided in this Questionnaire is, to the best of my/our knowledge, correct
- I/we will pay for the assessment
- I/we will respect the confidential nature of the assessment report and only circulate it to relevant professionals and for the purpose for which it was intended
- I/we will ensure access to the assessment report by all persons with parental responsibility for my/our child
- If you child is over 13 they need to give their permission for this questionnaire to be shared. Do they agree to it? Yes/No

Please note that the information recorded within this questionnaire will be used for the purpose of assisting the assessment. It is possible that some of this information may be recorded within the final assessment report. If you do have any sensitive or confidential information that you think is relevant, but which you either do not want to record or be recorded within the report, then please consider sharing this confidentially with the person performing the assessment and obtain agreement on how this information is to be used.

Signed:.....
Print name/s:.....
Relationship to child:.....
Date:.....

*If payment is to be made by another person or organisation, such as a bursary fund, please give details here:

Please ask your child’s school to complete the School Questionnaire and forward it to Dyslexia Support Consultancy.



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Please return this questionnaire to:-

Dyslexia Support Consultancy,

196 Hawthorn Way,

Lindford,

Hampshire

GU35 0RB