PARENT/CAREGIVER INTERVIEW

Child's Name_____Age____School_____Date of Birth_____
Person Completing Report _____Today's Date_____
Relationship to Child _____Student ID #_____Phone#_____
Mailing Address_____
Physical Address_____

PLEASE COMPLETE ALL ITEMS YOU FEEL COMFORTABLE WITH COMPLETING. IF YOU NEED HELP OR HAVE QUESTIONS CALL THE OFFICE OF SPECIAL PROGRAMS AT (304)256-4555 AND TELL THE SECRETARY THE SCHOOL YOUR CHILD ATTENDS. SOMEONE WILL PUT YOU IN CONTACT WITH THE SCHOOL'S CASE MANAGER. THANK YOU.

PRESENT PROBLEM

Explain the concern for your child_____
_____
_____
_____
When did your concerns begin? _____
What services and/or help does your child receive to address the concerns?
___ special education ___ counseling ___ behavior support ___ extra instruction ___ medication
Describe noticed changes in the child's academic performance_____
Describe noticed changes in the child's behavior_____
_____
Has the child received evaluation or treatment for the current problem or similar problems? (if yes, explain)
_____
What strategies/supports appear to work? _____
What strategies DON'T work? _____
What motivates your child? _____
Rate how your child gets along with others in school (1 poor – 5 great) 1 2 3 4 5
Rate how your child gets along with others in the community (1 poor – 5 great) 1 2 3 4 5
What teacher(s)/staff work best with you child? _____
What teacher(s)/staff does your child have trouble? _____
What student(s) get along best with your child? _____
What student(s) does your child have trouble? _____
Have you ever been to the school over these concerns? If so what was the outcome? _____
_____

FAMILY INFORMATION

Lives with: (check one) Biological Parent___ Family Member___ Adopted Parent___ Foster Parent___
Agency Involved (if applicable)? _____Age of placement_____
Mother's Name/Occupation_____Age_____
Father's Name/Occupation_____Age_____
Circle years of education completed:
Mother K 1 2 3 4 5 6 7 8 9 10 11 12 College Graduate Other
Father K 1 2 3 4 5 6 7 8 9 10 11 12 College Graduate Other

List of Individuals living in the home:

NAME	AGE	HEALTH STATUS	RELATIONSHIP TO CHILD

Have there been any of the following changes/stressors in the family? Please check and explain.

___ A move in the last 3 years (How many?)

_____

___ Divorce or separation of parents in the last 3 years

_____

___ Death or serious illness of an important family member in the last 3 years

_____

___ Current unemployment or monetary stress

_____

___ Unusual working hours

_____

___ New step parent or change in family structure in the last 3 years

_____

Is there a family history of any of the following? Please check all that apply:

___Mental Impairment	___Learning Disability	___Autism	___Developmental Delays
___Vision Problems	___Depression	___Anxiety Disorder	___Speech/Language Problems
___Drug Use/Abuse	___Hearing Problems	___Bipolar Disorder	___Schizophrenia
___Trauma	___Seizures/Epilepsy	___ADHA	___Physical/Mental abuse

___Other physical or mental health family history_____

Student Health History

Does your child have any diagnoses? Yes___ No___ If so, please list: _____

_____

What medications are prescribed and by whom? _____

_____

Counseling? If so by whom? _____

Has your child be evaluated by outside agencies? If so, list _____

_____

Are any other agencies involved with your child? If so list by name_____

How long does your child usually sleep at night? _____ Typical bed time? _____ Does he/she have trouble falling asleep? _____ Does he/she awake at night on a regular basis? ____ If so, usually how many times? ____

Please indicate the following health problems that your child exhibits now or has been chronic in the past.

___ Ear Infections	___ Breathing Problems	___ Diabetes	___ Frequent Headaches
___ Memory Problems	___ High Fever	___ Heart Problem	___ Convulsions/Seizures
___ Vision Problems	___ Extreme Tiredness	___ Hearing Problems	___ Lead Poisoning

___ Loss of Consciousness

Has your child had any of the following? (If yes, please explain in the space provided.)

___Head Injury_____

___Accidents_____

___Poisoning_____

___Surgery/Hospitalization_____

___Allergies_____

___Asthma_____

STUDENT'S BIRTH HISTORY

Age of mother at birth _____ Age of father at birth _____

Health of mother during gestation _____

Amount of Alcohol used by mother _____

Drugs and medications used by mother_____

Cigarettes: How much: _____

___ Premature	___ On Time	___ Late	Birth Weight_____
___ Head First	___ Cesarean	___ Reason	Other_____

Complications to baby_____
Did the baby need oxygen or resuscitation? _____
Was your child late to meeting any developmental milestones? (e.g. sitting, crawling, walking, talking, etc.) __
_____
If so, what milestones was he/she late to develop? _____

STUDENT'S SCHOOL HISTORY

Has your child ever been retained? _____ If so, what grade? _____
Has your child ever been suspended or expelled? (explain) _____
_____
_____
Have teacher complained about behavior problems? ____ if yes, what problems? _____
_____
_____
Does your child miss much school? (if so, explain) _____
Previous schools attended _____
What skills do you want your child to develop to be more independent? _____

STUDENT'S BEHAVIOR

What observable events allow you to predict misbehavior (task, time, peers, request, etc?) _____
_____
When/where is child successful during the school day? _____
When your child misbehaves what happens? _____
What type of discipline works for you? _____
Has your child ever been in trouble with the law? _____
What concerns do you have about your child's behavior? _____
_____
Does your child have difficulty with any of the following?

	YES	NO		YES	NO
Temper Tantrums	___	___	Nightmares	___	___
Thumb Sucking	___	___	Aggression	___	___
Impulsive	___	___	Overactive	___	___
Stubborn	___	___	Fearful	___	___
Takes Risks	___	___	Clumsy	___	___
Rocks	___	___	Bangs Head	___	___
Bites Nails	___	___	Pulls Hair	___	___
Uses Drugs	___	___	Uses Alcohol	___	___
Smokes	___	___	Odd Habits	___	___

COMMENTS: _____
_____
_____
_____

Signature of Person Completing Report_____ Date Completed_____