Carilion Children's Child Development Clinic
4348 Electric Road
Roanoke, VA 24018
Telephone (540) 769-0976
Fax (540) 857-5386

Dr. /NP _____
Appt._____
Received: _____

School Questionnaire

Please note that all information on this questionnaire will be added into the medical chart and shared with the family.

Date Completed_____

Child's Name_____ DOB_____ Grade _____

Name of School_____School District_____

Person completing form_____Position_____

Does the child receive remediation? ☐YES ☐NO If yes, in what area?_____

Does the child receive Special Education Services? ☐YES ☐NO Triennial_____

Special Education classification: *Primary*_____*Secondary*_____

Related Services_____

Is the child currently being evaluated for Special Education? ☐YES ☐NO

PLEASE attach any assessment reports (psychological, educational/developmental, speech, OT, PT), and a copy of the current IEP.

What are the child's **STRENGTHS**:

_____
_____
_____
_____
_____
_____
_____
_____

Are there concerns with aggressive behavior? ☐YES ☐NO

If YES, please explain: _____

_____

_____

_____

_____

Is the child able to transition between activities? ☐YES ☐NO

If NO, please explain: _____

_____

_____

_____

_____

Is the child able to adapt to changes in routine? ☐YES ☐NO

If NO, please explain: _____

_____

_____

_____

_____

Is anxiety observed in the classroom? ☐YES ☐NO

Is YES, please explain: _____

_____

_____

_____

_____

Does the child have any repetitive behaviors? ☐YES ☐NO

If YES, please explain: _____

_____

_____

_____

Are there concerns with social skills? ☐ YES ☐ NO

If YES, please explain: _____

_____

_____

_____

Does the child play appropriately with toys? ☐ YES ☐ NO

If NO, please explain: _____

_____

_____

_____

Are there concerns with speech? ☐ YES ☐ NO

If YES, please explain: _____

_____

_____

_____

Are there concerns with development/academics? ☐ YES ☐ NO

If YES, please explain: _____

_____

_____

_____

_____

Are there sensory concerns (*sound, touch, light*)? ☐ YES ☐ NO

If YES, please explain: _____

_____

_____

Atypical Behavior

PLEASE RATE CHILD	Never	Sometimes	Often	Very Often
Overly dependent on routine/rituals				
Overly sensitive to change in routine				
Shows interest in only a few objects/activities				
Performs repetitive routines				
Performs repetitive movements (waving, rocking, flicking fingers, etc.) Please explain:				
Play is often repetitive				
Intensely focuses on objects				
Intensely focuses on parts of objects (wheels, gears, etc.)				
Intensely focuses on movement of objects				
Obsession with objects, ideas or desires Please explain:				
Has unnatural posture: rigid floppy				
Exhibits unusual sensory interests (ex; licking, smelling) Please explain:				
Displays Extreme sensitivity (ex: to sound, lights, textures, food, etc) Please explain:				
Laughs for no apparent reason				
Cries for no apparent reason				
Tantrums for no apparent reason				
Causes injury to self				
Unusual attachment to objects Please explain:				

Additional Concerns:_____

_____

_____

_____

_____

_____

_____

WE APPRECIATE YOUR TIME AND ASSISTANCE