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| **Educational Questionnaire** | | | | | |
| STUDENT’S NAME: | | | | | |
| DATE OF BIRTH: | | | | | |
| NAME OF SCHOOL: | | | SCHOOL DISTRICT: | | |
| STUDENT’S GRADE LEVEL: | | | NUMBER OF STUDENTS IN CLASSROOM: | | |
| NUMBER OF TEACHER’S IN CLASSROOM: | | | | | |
| HAS THIS STUDENT EVER REPEATED A GRADE? YES/NO | | | IF SO, WHICH GRADE: | | |
| HAS THIS STUDENT EVER BEEN EVALUATED BY THE SPECIAL EDUCATION DEPARTMENT? **YES/NO** | | | | | |
| IF SO, WHEN? | | | WAS HE/SHE CLASSIFIED? | | |
| IF YES, WHAT CLASSIFICATION? | | | | | |
| DOES THIS STUDENT CURRENT HAVE AN IEP? **YES/NO** | | | | | |
| DOES THIS STUDENT CURRENTLY HAVE A 504 ACCOMMODATION/SUPPORT PLAN? **YES/NO** | | | | | |
| IF YES, PLEASE IDENTIFY SERVICES RECEIVED AND HOW OFTEN SERVICES ARE DELIVERED: | | | | | |
|  | **Frequency/Length of service per week/cycle** | **Remedial Instruction** | | **Supplemental Instruction** | **Push In or Pull Out** |
| **Reading Decoding** |  |  | |  |  |
| **Reading Comprehension** |  |  | |  |  |
| **Math Computation** |  |  | |  |  |
| **Math Applications** |  |  | |  |  |
| **Written Language** |  |  | |  |  |
| **Other** |  |  | |  |  |
| Does this student receive services from a special education teacher (inclusion classroom/blended classroom/consultant teacher/resource room/self-contained classroom)? **YES/NO** | | | | | |
| If yes, please explain: | | | | | |
| Does this student receive instruction outside of a general education classroom? **YES/NO** | | | | | |
| If yes. Please explain: | | | | | |
| Does this student receive related services (such as speech/language therapy/occupational therapy, physical therapy/counseling/adaptive physical education)? **YES/NO** | | | | | |

If yes, please identify service/s received and how often services are delivered:

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| --- | --- | --- | --- |
| **Service(s) received** | **Type of Service: Direct, indirect, and/or consult individual and/or group** | **Frequency & Length of service per week/cycle/month** | **Push - Push in or Pull Out** |
| **Adaptive physical education** |  |  |  |
| **Counseling** |  |  |  |
| **Occupational therapy** |  |  |  |
| **Physical therapy** |  |  |  |
| **Speech/language therapy** |  |  |  |
| **Aide/note taker** |  |  |  |
| **Other** |  |  |  |

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| Does this student have a modified curriculum? **YES/NO**  If yes, please explain: |
| Does this student have a 12-month program or receive services during the summer? **YES/NO**  If yes, please explain: |
| Does this student have an instructional team with an assigned case manager? **YES/NO**  If yes, please explain: |
| **If the child has had evaluations in the past including intellectual, achievement testing, language, speech, fine motor, gross motor, please include (attach) those evaluations.** |

**ACADEMIC ACHIEVEMENT**

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| --- | --- | --- |
| **READING** | **DECODING** | **COMPREHENSION** |
| **Current Reading Level** |  |  |
| **Reading Strengths** |  |  |
| **Reading Weaknesses** |  |  |

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| **MATHEMATICS** | **COMPUTATION** | **APPLIED MATH SKILLS** |
| **Current Math Level** |  |  |
| **Math Strengths** |  |  |
| **Math Weaknesses** |  |  |

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| **WRITTEN LANGUAGE** |
| **Current Level or Written Language Skills (spelling, grammar, ideas, syntax, organization)** |
| **Written Language Strengths** |
| **Written Language Weaknesses** |

**Grades/Achievement Test Scores/State Assessments**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Report Card Grades** | **School Year and Marking Period** | **Achievement Tests Scores/Date Given** | **State Assessments Scores/Date Given** |
| **Reading** |  |  |  |  |
| **Mathematics** |  |  |  |  |
| **Spelling** |  |  |  |  |
| **English/Lang. Arts** |  |  |  |  |
| **Science** |  |  |  |  |
| **Social Studies** |  |  |  |  |
| **Other** |  |  |  |  |
| Are there any concerns or problems regarding academic achievement (completing homework, test anxiety, class participation? **YES/NO**  If yes, please explain: | | | | |

**PLEASE COMMENT ON THE FOLLOWING AREAS:**

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| **AREA** |
| **Verbal expression/Ability to communicate (please note any strengths or problems with vocabulary, organizing & expressing ideas, speech intelligibility)** |
| **Auditory processing (please note any strengths or problems with following/understanding directions, understanding aural presentations)** |
| **Fine motor & gross motor skills:** |
| **Home/family environment:** |
| **Organizational skills:** |
| **Peer Relationships (please provide specific details):** |
| **Behavior (does student exhibits symptoms of hyperactivity, impulsivity, distractibility, inattention, aggressive behavior, oppositional behavior, withdrawal, tantrums or other behavioral concerns)** |

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| Does the child have trouble with transitions? **YES/NO** | |
| Is the child overly rigid? **YES/NO** | |
| Has an FBA (Functional Behavioral Assessment) been completed? **YES/NO** | |
| If yes, when? | Who Completed? |
| Please indicate which instructional strategies, procedures or methods you have found successful: | |
| Ability to profit from current instructional program: | |
| Are there any issues/concerns you feel are essential to this evaluation? **YES/NO**  If so, please explain: | |
| Questions you would like addressed: | |

Name/s of person(s) completing this questionnaire:

|  |  |  |
| --- | --- | --- |
| ***Name*** | ***Title/Position*** | ***Date*** |
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**Upon completion, please return this questionnaire along with copies of evaluations and/or test reports to:**

**Caryn Garriga, M.D.**

**249 Clarkson Road, Suite 102**

**Ellisville, MO. 63011**

**FAX: (636) 527-8912 | PHONE: (636) 527-8900**