



Dyslexia Parental Questionnaire

Dyslexic difficulties can range from being mild to severe. Children with dyslexia often present a 'puzzle' to those who know and teach them.

If teachers and parents share information, they can build up a clear picture of factors that may be significant. School can then ensure that suitable types of teaching are used to help your child learn in the particular way that is most effective.

This information questionnaire may clarify questions or concerns that have been raised by parents or school and support understanding.

Developmental History

Was your child born prematurely?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
How would you describe your child's development in:			
Crawling	Delayed <input type="checkbox"/>	Early <input type="checkbox"/>	Average <input type="checkbox"/>
How long were they crawling?	_____		
Rolling onto back and front	Delayed <input type="checkbox"/>	Early <input type="checkbox"/>	Average <input type="checkbox"/>
Passing Objects from one hand to another	Delayed <input type="checkbox"/>	Early <input type="checkbox"/>	Average <input type="checkbox"/>
Walking	Delayed <input type="checkbox"/>	Early <input type="checkbox"/>	Average <input type="checkbox"/>
Talking	Delayed <input type="checkbox"/>	Early <input type="checkbox"/>	Average <input type="checkbox"/>
Riding a bike	Delayed <input type="checkbox"/>	Early <input type="checkbox"/>	Average <input type="checkbox"/>
Catching a ball	Delayed <input type="checkbox"/>	Early <input type="checkbox"/>	Average <input type="checkbox"/>
Were you told of any delays in your child's development? (e.g. playing with others, playing with toys, playing imaginatively)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Is he/she accident prone?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Are they	Right handed <input type="checkbox"/>	Left handed <input type="checkbox"/>	Undecided? <input type="checkbox"/>

Speech Skills

Has your child ever been referred to the Speech & Language Service?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Did your child make 'baby talk' before talking?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
At what age did she/he learn to join two or more words together?	_____ yrs _____ mths	
Has your child had difficulty with any of the following?		
Stuttering	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Slurring	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Expressing themselves	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have any concerns about your child's speech now?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Child's Reading Development

Does your child:		
Like you to read to them?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Enjoy looking at books for pleasure?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Show any interest in reading for themselves?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Did/does your child:		
Guess words?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have difficulty remembering the names of objects?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Use jumbled phrases?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Have difficulty learning Nursery Rhymes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Find it difficult to give rhyming words?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have "good" and "bad" days?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have difficulty following a pattern? E.g. beads	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was your child:		
Good at early years shape matching e.g. shape posting boxes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Good at finding matching cards in early years card games?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Good at jigsaws?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

During or after reading do they or have they ever complained of:				
	Letters		Words	
Text blurring	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Double vision	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fatigue	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Eyes watering	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Memory Abilities

Does or has your child had difficulties with:		
Putting the days of the week in order	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Months of year	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lists	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Remembering Alphabet	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Names	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Dates		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Colours/shapes		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Directions	Left/Right	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Up/Down		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Front/Back		Yes <input type="checkbox"/>	No <input type="checkbox"/>

Listening Skills

When your child listens, do you feel he/she:

Clearly understands what is said?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Needs time to respond?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Finds it difficult to concentrate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Can concentrate if they are interested?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Overall concentration span is	Variable <input type="checkbox"/>	Normal <input type="checkbox"/>	Poor <input type="checkbox"/>

Attention

Does your child:

Often make careless mistakes in school work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Often find it difficult to sustain attention to tasks/play?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Often not complete tasks?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Often lose things necessary for tasks (e.g. books)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Often have difficulty in organising tasks or activities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Often avoid tasks that require sustained mental effort?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your child:		
Often forgetful during routine daily activities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Easily distracted?

Yes

No

Writing

Does your child enjoy writing?

Yes

No

Energy Levels

Do you feel your child gets enough sleep?

Yes

No

Is your child:

Often 'on the go' or hyperactive?

Yes

No

Does your child:

Often have difficulty awaiting their turn?

Yes

No

Find it difficult to sit down for any length of time?

Yes

No

Often talk excessively?

Yes

No

Has your child's energy level since birth been:

Consistent
over time

Increasing

Decreasing

Does/did your child:

Have difficulty with buttons/laces?

Yes

No

Confuse left/right, feet/shoes?

Yes

No

Do you think your child is clumsy/uncoordinated?

Yes

No

Can your child:

Ride a bike?

Yes

No

Hop and skip?

Yes

No

Throw and catch a ball?

Yes

No

Is your child:

Forgetful?

Yes

No

Unable to remember what he/she has been told to do?

Yes

No

Disorganised?

Yes

No

Unable to work out how a to do a task, such as tidying away toys?

Yes

No

What does your child like doing?

What do you think your child does well?

What things does your child like/find easy at school?

What things does your child not like/find difficult at school?

Do you think your child finds school enjoyable?

Yes

No

Is there a history of dyslexia in your family?

Yes

No

Have other members of your family had difficulty with reading and spelling?

Yes

No

Have other members of your family had difficulties associated with any of the following?

Dyspraxia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Balance Disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Attention Deficit Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Speech and Language Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aspergers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Autism	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sight	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hearing	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Have you any other comments you would like to add?

After completing this questionnaire please discuss it with your child's teacher and/or SENCo at the school. They will decide what needs to be done to help your child.

If you would like help, please contact:

 **SN-IP** www.snipnorthants.org

Special Needs - Informed Parents

Springfield, Cliftonville,
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Fax:01604 630283

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This information can be made available in other languages and formats upon request.