FOUNDATIONS CHRISTIAN ACADEMY

Part I – Student & Family Information

Student Name: _____

Date of Birth: _____Age: _____

Parent/Guardian Name(s): _____

Address:_____

Email Address:_____

Home Phone: _____Work Phone: _____Cell Phone: _____

Immediate Family Members (Name / Relationship / Age):

_____

_____

_____

Part II – Developmental & Early History

Did the mother experience health problems during pregnancy?

☐ Yes ☐ No

If yes, explain: _____

Were there any birth conditions?

☐ Premature ☐ Breech Birth ☐ Blood Incompatibility

☐ Induced ☐ Caesarean ☐ Fetal Distress

☐ Prolonged Labor ☐ Forceps/ Vacuum ☐ Other: _____

☐ Fast Labor ☐ Oxygen Problems

Was your child born:

☐ Full-term ☐ Late

☐ Preterm ☐ Low birth weight

Feeding as an infant:

☐ Breastfed How long? ____ ☐ Feeding difficulties (explain):

☐ Bottle-fed

As a baby, your child was:

☐ Very active

☐ Very still

☐ Needed assistance to sleep/wake

Did your child have difficulty learning to eat, sleep, sit, walk, or talk?

☐ Yes

☐ No

If Yes Please Explain:_____

Did your child suck thumb beyond age 5?

☐ Yes ☐ No

Did your child wet the bed beyond age 5?

☐ Yes ☐ No

Part III – Medical History

Check all that apply:

☐ Allergies

☐ Asthma

☐ Frequent Colds

☐ Frequent Ear Infections

☐ Frequent Sore Throats

☐ Eye/Vision Problem

☐ Speech Problems

☐ Headaches

☐ Dietary Problems

☐ Epilepsy

☐ Serious Accidents

☐ Operations

☐ Heart Disease

☐ Diabetes

☐ Hospitalizations How long and at what age?

☐ Other

Is your child currently on medication or under treatment?

☐ Yes ☐ No

If yes, explain: _____

General health:

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Part IV – Social, Behavioral & Learning Characteristics

Check all that apply to your child:

- ☐ Flexible
- ☐ Cooperative
- ☐ Outgoing
- ☐ Creative
- ☐ Musical
- ☐ Artistic
- ☐ Athletic
- ☐ Mechanical
- ☐ Self-confident
- ☐ Enjoys reading
- ☐ Gets ideas quickly
- ☐ Daydreams
- ☐ Fantasizes
- ☐ Rocky

Concerns/Behaviors:

- ☐ Bedwetting
- ☐ Thumb sucking
- ☐ Nail biting
- ☐ Nightmares
- ☐ Temper Tantrums
- ☐ Overactive
- ☐ Underactive
- ☐ Frequent sudden mood changes
- ☐ Short attention span
- ☐ Lacks self-control
- ☐ Needs reassurance
- ☐ Unusually aggressive
- ☐ Shy/withdrawn
- ☐ Difficulty making friends
- ☐ Difficulty completing tasks
- ☐ Difficulty with organization
- ☐ Difficulty with changes
- ☐ Difficulty with reading
- ☐ Difficulty with numbers
- ☐ Difficulty telling time
- ☐ Avoids homework
- ☐ Avoids reading

☐ Frequent lying

☐ Frequent tardiness

☐ Talks to self

☐ Doesn't understand directions

☐ Sleepwalking

☐ Lacks motivation

☐ Uncooperative

☐ Unreasonable fears

☐ Inconsistency in behavior

Comments on behaviors that concern you: _____

Part V – Learning & Developmental Skills

Did your child crawl on all fours?

☐ Yes ☐ No

If no:

☐ Army crawl ☐ Bum scoot

Did your child walk after 16 months?

☐ Yes ☐ No

Did your child have difficulty learning to read/write in the first 2 years of school?

☐ Yes ☐ No

Does your child struggle with:

☐ Sitting still

☐ Staying focused

☐ Copying from the board

☐ Left/right awareness

☐ Learning to tell time

☐ Riding a bike

☐ Catching a ball

☐ Skipping/climbing/somersaults

Does your child make frequent mistakes when writing/copying?

☐Yes ☐No

Part VI – Emotional & Sensory

Has your child experienced traumatic events (death, divorce, family crisis)?

☐ Yes ☐ No

If yes, explain: _____

_____

Does your child show heightened reactions to:

☐ Loud noises ☐ Crowded environments

☐ Bright lights ☐ Unexpected change

Does your child experience:

☐ Anxiety/panic ☐ Poor balance

☐ Migraines ☐ Allergies/eczema

☐ Dizziness/nausea ☐ Coordination difficulty

Part VII – Family & School History

Do you have any serious concerns about your child?

☐ Yes ☐ No

If yes, explain: _____

Has any family member experienced school-related problems?

☐ Yes ☐ No

If yes, explain: _____

_____

Is there a family history of similar difficulties (learning, sensory, anxiety, trauma)?

☐ Yes ☐ No

Does your child have any Diagnoses?

☐Yes ☐No

If yes, explain:

_____

_____

PARENT QUESTIONNAIRE

Please complete the following as accurately as possible

Child's name: Grade: Age: Date of Birth:

Mother/Guardian's name: Today's Date:

Father/Guardian's name:

Child lives with?

Ear Tubes? Glasses/Contacts?

Phone Number: Address:

Please remember to keep in mind; this information gives us a base line of where to start with your child. We do not need answers based on how you would like things to be, but how they actually are right now. Thank you for your valuable input.

BIRTH		
Birth weight:	Born on time? y N	If not, which week?
Any problems during delivery? y N	Any problems after delivery? y N	Cesarean? y N
Other complications?		
Breast fed? y N	How long?	
Any current medications		

Circle the degree of challenges on a scale: 0 = No Challenge, 3= Moderate Challenge, and 5 = Severe challenge.

PRESENT CHALLENGES			
1.Fear of the dark, or fear of anything else, anxiousness	0 1 2 3 4 5	16. Slumps at table or props head up	0 1 2 3 4 5
2.Avoids social situations or extremely shy	0 1 2 3 4 5	17. Poor hand-eye coordination or difficulty catching a ball	0 1 2 3 4 5
3. Freezes in stressful situations	0 1 2 3 4 5	18. Sits on knees or in W position	0 1 2 3 4 5
4. Aggressive outbursts or impulsive	0 1 2 3 4 5	19.Can't sit still in chair	0 1 2 3 4 5
5. Sensitive to light, sound, smell, touch, or tight clothing, or motion	0 1 2 3 4 5	20. Poor concentration or poor short term memory	0 1 2 3 4 5
6. Highly emotional or meltdowns	0 1 2 3 4 5	21. Difficulty potty training or wetting bed after age 5	0 1 2 3 4 5
7. Speech Problems	0 1 2 3 4 5	22. Hyperactive	0 1 2 3 4 5
8. Mouth movements when writing or drawing or writing difficulties	0 1 2 3 4 5	23.Poor auditory processing or misunderstanding directions	0 1 2 3 4 5
9. Nail biting or chews objects	0 1 2 3 4 5	24.Shallow breathing or mouth breathing	0 1 2 3 4 5
10. Poor Posture	0 1 2 3 4 5	25. Toe walking or flat footed	0 1 2 3 4 5
11. Spatial awareness challenges or runs into people or things	0 1 2 3 4 5	26.Walks with toes pointed inward or outward	0 1 2 3 4 5
12. Difficulty holding head up	0 1 2 3 4 5	27. Dislikes wearing shoes	0 1 2 3 4 5
13. Poor gross and fine motor skills	0 1 2 3 4 5	28. Easily Frustrated	0 1 2 3 4 5
14. Difficulty reading: writing: spelling:	0 1 2 3 4 5 0 1 2 3 4 5 0 1 2 3 4 5	29.Difficulty hopping: skipping: jumping:	0 1 2 3 4 5 0 1 2 3 4 5 0 1 2 3 4 5
15. Difficulty crossing the midline (e.g. messy eater or can't tie shoes)	0 1 2 3 4 5	30. Depression	0 1 2 3 4 5

Parent Goals for Student

Please fill out some goals that you would like for your student to work towards here at FCA.

Academic Goals

1. _____
2. _____
3. _____

Social Goals

1. _____
2. _____
3. _____

Spiritual Goals

1. _____
2. _____
3. _____

Athletic Goals

1. _____
2. _____
3. _____