Child Screening Questionnaire

Date ______________
Child's Name_________________________
Date of Birth ___________________
Grade ________________

This is a questionnaire to gather some information on your child's cognitive condition.

Please answer YES (Y) or NO (N) of Don't Know (D) to the following questions.

1. Has your child ever been diagnosed by a professional (doctor, psychologist, diagnostician) as having a problem with any of the following?
A) Reading Disability ___________
B) Learning Problem ___________
C) Depression _______________
D) Delayed Speech _______________
E) Stuttering ______________
F) Other Speech Impairments ______________
G) Attention Deficit Disorder or Hyperactivity ________________

2. Has your child ever experienced a head injury? _____________
If Yes, was your child unconscious at the time? ___________
If yes, for how long approximately? ___________
Was your child hospitalized at the time for the injury? ___________

3. Please answer the following questions about hand preference.

Is your child right or left handed? ______________
Which hand does your child write with? ________________
If your child uses one hand for some activities and the other of other activities, please explain?