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?