Columbus City Schools

Department of Special Education - Psychological Services

PARENT INTERVIEW

Student Name:_____

STUDENT BACKGROUND:

What adults and children live in the home? _____

_____

Ages of other children in home:_____

_____

Any history of special education or mental health issues in family, please specify (including siblings)?_____

_____

_____

Parent(s) employment:_____

_____

Have there been any family changes in the last 3 years? (For example, death in family, divorce or remarriage, new siblings…)_____

_____

School history: Number of schools attended?_____

Name of schools attended?_____

Attendance good or poor, if poor, please explain?_____

_____

Has the student ever been retained, if so, what grade?_____

ACADEMIC, SOCIAL, and LIFE SKILLS:

What activities/ interests does the student enjoy?_____

_____

My child needs extra help in the following areas:

Reading___	Math___	Written Expression___
Social Skills___	Vocational Skills___	Study Skills___
Self-Help Skills___	Organization___	Attention/ Focus___

Behavior: ___(Be specific)_____

Other:_____

Please list areas of strength for your child (academic, social, behavioral…)_____

_____

Has your child ever received private tutoring or counseling?_____

If so, for what reason?_____

Where?_____

Dates/Ages?_____

HEALTH and MEDICAL INFORMATION:

Does the student have an existing medical condition? (For example, diabetes, asthma, ADHD)_____

_____

In the last three years has the student experienced any serious illnesses or been hospitalized? Please explain._____

_____

_____

Has your child ever it his/her head, or get hit in the head? Yes___ No__

Did your child ever lose consciousness or have a concussion? Yes___ No___

Please explain:_____

_____

Did your child ever have surgery to the head or brain? Yes___ No___

Has your child ever had a stroke? Yes___ No___

Has your child ever been diagnosed with a brain tumor? Yes___ No___

If yes to any question stated above, did he/she experience any problems after the injury such as:

Headaches___ Irritability___ Dizziness___ Anxiety___
Depression___ Increased Fatigue___ Poor Judgment___
Attention/ Focusing___ Long or Short Term Memory___ Academics___
Problem Solving___ Reasoning/ Judgment___ Changes in Friends___
Other:_____

Has your child ever been taken to the emergency room or had any other type of surgery? (Please explain)_____
_____

Do you suspect problems with: Vision___ Hearing___

Does the student: Wear Glasses___ Have Hearing Aides___

Does the student take any medication: Yes___ No___. If yes, what medication and for what reason?_____

Does your child have any other medical conditions/ concerns not already mentioned?____
_____

ADDITIONAL INFORMATION:

Please write below any other information you think is important to know about the student:_____
_____
_____

Completed By:_____ Date:_____