ACE Academy

Parent Questionnaire

Confidential Background Information (Please feel free to write on the back)

Child's Name: _____ Nickname: _____

Birth date: _____ Place of Birth: _____ Age: _____ Sex: _____

Home Address: _____

Number *Street*

_____

City *State* *ZIP code*

Ethnicity: _____ Hair Color: _____ Eye Color: _____

Family Information

Parent I

Name: _____ Phones: _____

Email Address: _____

Occupation and title: _____

Employer: _____

Education - College and any Post-Graduate work:

School(s):	Degree(s) or # of Years:	Major(s)/Specialties:

Other training, relevant background, and interests:

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Parent II

Name: _____ Phones: _____

Email Address: _____

Occupation and title: _____

Employer: _____

Education - College and any Post-Graduate work:

School(s):	Degree(s) or # of Years:	Major(s)/Specialties:

Other training, relevant background, and interests:

Any other Parent(s) present in child's life:

Name: _____ Phones: _____

Email Address: _____

Occupation and title: _____

Employer: _____

Education - College and any Post-Graduate work:

School(s):	Degree(s) or # of Years:	Major(s)/Specialties:

Other training, relevant background, and interests:

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Child's nuclear family and household (Please list all adults and children):

Name	Relationship to child	Age	Living in home?

Activities enjoyed as a family:

Relationship with mother:

Relationship with father:

Relationship with siblings:

School Information

School attending: _____ Present Grade: _____

Child presently: likes school / hates school / is indifferent (circle one).

Academic Strengths and favorite school activities:

School problems and areas of concern from parents' point of view. Include length of time any problems have been occurring and frequency:

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Concerns teachers have reported about your child. Include length of time any problems have been occurring and frequency:

Typical grades in school:

Earlier School Experiences:

Number of schools child has attended:

Retention in school? Y / N
If so, at what grade level:

Acceleration in School? Y / N
If so, at what grade level:

Reason for retention/acceleration:

Psychological, Developmental, and Medical Information

Previous testing information:

Type of Test	Date Administrered	Reason for Test	Administered by	Results

Medical/Psychiatric Conditions: (please check all that apply)

___ no major medical or psychiatric concerns
___ asthma
___ an attention deficit disorder
___ an attention deficit hyperactivity disorder
___ chronic ear infections
___ depression
___ anxiety
___ diabetes
___ lead poisoning
___ multiple sclerosis
___ muscular dystrophy
___ a seizure disorder
___ severe allergies
___ Spina Bifida
___ Fetal Alcohol Syndrome
___ other

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Neurological Status: (please check all that apply)

In the Past	Recently
___	___ no signs of neurological concerns
___	___ episodes of head banging
___	___ seizures or convulsions
___	___ a serious head injury
___	___ periods of unconsciousness
___	___ an unusual number of accidents
___	___ a motor tic

Describe any neurological areas of concern checked above:

Please briefly describe your child's allergies, ear infections, high fevers, or illnesses, and any other distinguishing health history and physical conditions:

Illnesses, hospitalizations, and or operations. Include reason and age of child:

Current medications:

Pediatrician: _____ Other physicians seen: _____

Has your child ever developed a temporary tic? Y / N
Age it started and age it disappeared: _____

What were the circumstances going on in the child's life when the tic started? When the tic disappeared, did anything change in the child's life?

Sensory Motor:

Vision Screening: _____ Hearing Screening: _____

Date of latest testing: _____ Date of latest testing: _____

Results: _____ Results: _____

___ has no sensory or motor difficulties
___ has no visual difficulties
___ is to wear corrective lenses
___ has mild hearing difficulties
___ has substantial hearing difficulties
___ eyes do not track together
___ has an allergy related difficulty
___ is supposed to wear a hearing aid
___ has pressure equalization (P/E) tubes
___ has fine motor movement difficulties
___ has gross motor movement difficulties
___ frequently bumps into things

Can your child ride a bike without training wheels? Yes / No At what age did they start? _____

Energy level and sleep needs:

Was child adopted? _____ If so, at what age? _____

If so, please answer pregnancy questions in terms of child's birth mother (if known):

Pregnancy and Birth Information: (please check all that apply)

___ was born with no apparent complications
___ experienced anoxia at birth
___ experienced in utero exposure
___ required assistance with breathing
___ natural birth
___ Caesarean-section
___ spent time in neonatal intensive care
___ was born past due date
___ was born premature
___ weighed less than 5 ½ pounds at birth
___ induced

Birth weight: _____

Other Pregnancy Issues (include any difficulties, e.g. whether mother smoked, drank alcohol, took drugs, medical illnesses, or any health problems of the mother):

Birth Issues (include any other complications, e.g. natural versus induced, breech, Apgar score, and duration of pregnancy):

Family History (include whether anyone else in the family skipped a grade, participated in gifted and talented classes, had high academic achievement, had/has ADHD, dyslexia, seizures, learning issues, etc.)

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Developmental History (as best you remember)

Age held head up? _____ Age turned over? _____ Age smiled at parents? _____
Age crawled? _____ Age sat w/o help? _____ Age pulled up at crib? _____
Age walked with help? _____ Age walked alone? _____ Age bottle fed? _____
Breast fed? _____ Age weaned? _____ Age said 4-10 words? _____
Age used sentences? _____ Speech problems? _____
Shy or timid? _____ Likes attention? _____ Friendly baby? _____
Affectionate? _____ Wanted to be left alone? _____ Stubborn? _____
More interested in things than in people? _____
Ate well? _____ Age fed self? _____ Breath holding? _____
Temper tantrums? _____
Tears up toys more than normal? _____ Much too active? _____
Age bowel trained, night? _____ Day? _____ Age helped with dressing? _____
Age stayed dry, night? _____ Day? _____ Right or left handed? _____
Well coordinated? _____ Clumsy? _____ Good with hands? _____
Blank spells? _____ Fainting spells? _____ Rocking? _____
Dare-devil behavior? _____ Impulsiveness? _____ Head bumping? _____
Unusual fears? _____

Reading Skill Development (include age read first word, read multiple words, read chapter books):

History of learning English, if a second language:

Relationship with other children (outside the family):

Name at least three adjectives that best describe your child:

Particular assets and strengths:

Other Personality Characteristics:

Sensitivity:

Sense of humor:

Needs and ways to be in control:

Fears, anxieties and other problems:

Favorite activities:

Special lessons and extracurricular activities:

How do you discipline at home? For what problem behaviors? Which motivation and learning methods are usually effective?

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Particular reasons for testing and/or counseling now:

Any other information that might help your child:

Completed by: _____ Relationship to child: _____

Date: _____

Please mail to:

Karen Langdon, Director of Admissions
ACE Academy
3801 N. Capital of Texas Hwy.
E 240-158
Austin, Texas 78746

ACE Academy admits students of any ancestry, citizenship, ethnicity, family status, gender identity, gender expression, disability, race, color, religion, nationality, ethnic origin, sex, or sexual orientation to all rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of ancestry, citizenship, ethnicity, family status, gender identity, gender expression, disability, race, color, religion, nationality, ethnic origin, sex, or sexual orientation in administration of its educational policies, admissions policies, financial aid programs, and athletic and other school-administered programs.