



700 Frederick St. #204, Santa Cruz, Ca. 95062  
Phone (831) 429-5987 Fax (831) 429-5993  
Website: dls-learning.com

## Parent Questionnaire

Date: \_\_\_\_\_

The information requested below is desired for the purpose of gaining an understanding of the applicant. Please answer questions as fully as possible and return this form to DLS at the above address at least one week prior to the appointment. It is helpful to have both parents participate in the completion of this form. Please make any additional copies or give us a call and we will mail extra copies.

Applicant Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father's Email: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Email: \_\_\_\_\_

Name of School: \_\_\_\_\_

School Address: \_\_\_\_\_

Contact Person (Teacher, Counselor, Principal, Etc.): \_\_\_\_\_

Please indicate the specific reasons for the observation/assessment:

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### Family History

Parents	Mother	Father
Occupation	_____	_____
Birthplace	_____	_____
Marital Status	_____	_____
Any Education Problems	_____	_____
Language Spoken in Home	_____	_____

Siblings	Oldest	Next Oldest	Next	Next
Age	_____	_____	_____	_____
Sex	_____	_____	_____	_____
Grade Completed	_____	_____	_____	_____
Any Social or Educational Problems	_____	_____	_____	_____

### Development and Medical History

Were there any unusual conditions during the mother's pregnancy or birth? If so, please describe:

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Is this child or any sibling adopted? \_\_\_\_\_

With whom does your child live? \_\_\_\_\_

Any recent changes in the family (births, deaths, etc.)? \_\_\_\_\_

Did any of the following occur late than expected? If so, when?

- ~ First Tooth \_\_\_\_\_
- ~ Creeping \_\_\_\_\_
- ~ Crawling \_\_\_\_\_
- ~ Voluntary Control of Bladder \_\_\_\_\_
- ~ Sitting Alone \_\_\_\_\_
- ~ Walking Alone \_\_\_\_\_
- ~ Feeding Self \_\_\_\_\_

How old was the applicant when single words were first attempted? \_\_\_\_\_

How old was the applicant when simple sentences/phrases were first attempted? \_\_\_\_\_

Is applicant right-handed or left-handed? \_\_\_\_\_

Has anyone ever attempted to change applicant's handedness? \_\_\_\_\_

Has applicant had any serious accidents, operations, or unusual illnesses, such as high fever, prolonged confinement, head injury, seizures etc.? If so, please specify accidents and/or illnesses and the dates they occurred. \_\_\_\_\_

\_\_\_\_\_

Did your child have frequent ear infections (more than four within twelve months time)? \_\_\_\_\_

\_\_\_\_\_

What age child does the applicant prefer to work or play with? (Older, younger, same, sex, alone)

\_\_\_\_\_

Does the school consider the applicant to have a learning discipline problem? \_\_\_\_\_

\_\_\_\_\_

Do you believe that your child has a learning problem? \_\_\_\_\_

\_\_\_\_\_

Does applicant have any chronic physical problems? If so, what is the nature of the problem?

\_\_\_\_\_

\_\_\_\_\_

Is applicant currently taking medication? If so, what kind? \_\_\_\_\_

\_\_\_\_\_

Reason medication prescribed? \_\_\_\_\_

\_\_\_\_\_

How would you describe applicant's vision? Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Date of last vision check. \_\_\_\_\_ By whom? \_\_\_\_\_

How would you describe applicant's hearing? Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Date of last hearing check. \_\_\_\_\_

By whom? \_\_\_\_\_

Do you feel applicant's mental ability is:

Low \_\_\_\_\_ Average \_\_\_\_\_ Above Average \_\_\_\_\_ Superior \_\_\_\_\_

Does the applicant participate in sports? \_\_\_\_\_

Are applicant's sleeping habits regular? \_\_\_\_\_

At what time does applicant go to bed? \_\_\_\_\_

Are applicant's eating habits regular? \_\_\_\_\_

Shown any recent changes in eating habits? \_\_\_\_\_

How many hours a day does applicant watch television? \_\_\_\_\_

Does the applicant complain about not feeling well? \_\_\_\_\_

## School Adjustment

Please list the schools applicant has attended.

If preschool, please indicate.

Name	Location	Grade Level
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please evaluate applicant's general achievement in school.

Grade Level	Very Poor	Poor	Average	Above Average
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please evaluate the applicant's effort toward school.

	Dislikes/Low			Likes/High	
1. Student attitude of school.	1	2	3	4	5
2. The level of effort the student put out for school.	1	2	3	4	5
3. Attention to school details.	1	2	3	4	5
4. Attention span.					
-Working with someone.	1	2	3	4	5
-Working alone.	1	2	3	4	5
5. Listening ability.	1	2	3	4	5
6. Follows through.	1	2	3	4	5
7. Organization.	1	2	3	4	5

Does the school believe your child has a learning problem? \_\_\_\_\_

Do you believe that your child has a learning problem? \_\_\_\_\_

Does applicant have a speech defect? \_\_\_\_\_

If so, has any attempt been made to correct it? \_\_\_\_\_

By whom? \_\_\_\_\_

What was the date of applicant's last physical examination? \_\_\_\_\_

Did the school recommend any special education services? \_\_\_\_\_

What is the applicant's attitude toward school? \_\_\_\_\_

What is the applicant's attitude toward teachers in general? \_\_\_\_\_

How would you rate applicant's popularity among classmates? (Ignored, rejected, accepted, has many friends of both sexes, etc.) \_\_\_\_\_

### **Family and Home Situations**

How does applicant get along with his/her siblings? \_\_\_\_\_

What type of discipline is most effective in guiding applicant? \_\_\_\_\_

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Are there any adults besides the parents who play an active role in guiding applicant? If so, whom? \_\_\_\_\_

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Does applicant have responsibilities in the home? \_\_\_\_\_

What are the special interests of the applicant? \_\_\_\_\_

Has applicant ever repeated a grade in school? \_\_\_\_\_

If so, how did the applicant react to retention? \_\_\_\_\_

Has applicant received any special help in subjects in school? (tutoring in math, reading, etc)

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**Inventory** - Choose the number that best corresponds with the applicant's behavior.

	Never	Sometimes	Usually	Always
1. Demonstrated interest in solving any new problems.	1	2	3	4
2. Willingness to ask questions about problems he/she does not understand.	1	2	3	4
3. Ability to express or demonstrate understanding of new ideas or concepts.	1	2	3	4
4. Ability to solve any new problems.	1	2	3	4
5. Willingness to work/play alone.	1	2	3	4
6. Willingness to work/play with others.	1	2	3	4
7. Ability to follow directions.	1	2	3	4
8. Ability to communicate directions or instructions to others.	1	2	3	4

- |     |                                                                      |   |   |   |   |
|-----|----------------------------------------------------------------------|---|---|---|---|
| 9.  | Notices physical changes in his/her environment.                     | 1 | 2 | 3 | 4 |
| 10. | Coordination in relation to objects in his/her physical environment. | 1 | 2 | 3 | 4 |

Please describe any other characteristics of the applicant that we should be aware of to meet his/her needs as fully as possible. \_\_\_\_\_

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Applicant



# Developmental Learning Solutions

700 Frederick St. #204, Santa Cruz, Ca 95062

## Information Release and Request Form

Applicant's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Please Initial Below:

**Medical, Hospital, or Consulting Agencies Records**  
 Yes \_\_\_ No \_\_\_ I hereby consent that Developmental Learning Solutions may be given or receive information related to the client's physical or psychological condition from any physician, mental health professional, hospital, or agency associated with the applicant.

**Health Service**  
 Yes \_\_\_ No \_\_\_ In the case of emergency, I hereby authorize a staff member of Developmental Learning Solutions to secure medical assistance for the client. This authorization is to be enforced when the client is not accompanied by his/her parent(s) or guardian(s).

**Educational Consultant**  
 Yes \_\_\_ No \_\_\_ I hereby understand that Developmental Learning Solutions may be given or receive information when deemed necessary from the school district, school, tutor, teacher, reading specialists, or other educational staff associated with the applicant.

Yes \_\_\_ No \_\_\_ I hereby understand that two copies of the assessment will be given only to the parent(s) or individual paying for the test. For every additional copy there will be a fee.

Yes \_\_\_ No \_\_\_ I understand that the information on the client remains confidential and will not be released unless a letter from the client, parent, or sponsor states that the release of information is permitted.

Yes \_\_\_ No \_\_\_ I hereby consent that the case information may be used as research data with the complete removal of identification of the client.

Yes \_\_\_ No \_\_\_ I understand that the professional and graduate staff of Developmental Learning Solutions may observe, share information, and review each case study as a complete, functioning unit.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

## Policy/Billing Statement

We are grateful that you have chosen Development Learning Solutions to serve your family's educational needs. We thank you also for the opportunity to present our policies and billing statement for your review.

Our policy is outlined below. After reviewing, please sign one copy and return it to our office prior to receiving any services. The second copy is for your records.

1. Barring emergencies, please keep all scheduled appointments. This ensures consistency for you and/or your child, and the possibility that remediation will occur more rapidly.
2. If you are unable to attend a session, please give at least a 24-hour notice. *Cancellations of less than 24 hours will result in a charge for a full session.*
3. Unless other arrangements have been made, payment is expected at the time of service. A discount plan is available for *some* services. In order to be eligible for this discount you must pay *in advance* for services.
4. Each session is 50 minutes, unless otherwise agreed upon.
5. If a school observation or meeting (IEP 504) is necessary, a fee is charged.
6. In-person parent or teacher conferences are periodically necessary. Unless otherwise agreed upon, clients are charged the regular session fee for these conferences.
7. There are possible periodic fee increases. If this will affect you, you will receive 30-day advance notice.

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Signature

Date

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Client's Name

Rates Effective November 12, 2008

Full Assessment: \$1,800

(We provide 2 copies of the report. Should you need an additional copy the cost is \$12)

Intake: \$135

Educational Specialists: \$75.00 to \$125.00 per 50 minute session.

Tutoring: \$50.00 per 50 minute session.

Speech Pathology: \$90 to \$110 per 50 minute session.

Vocational Counseling: \$80 per hour

Study Hall: \$25 per hour.

Exam Proctoring: \$30 per hour for DLS clients. Non-DLS clients: \$45 per hour.

Misc. Charges: These apply for phone conferences, school meetings, transportation.

Discount Plan: We do offer a pre-payment plan at a discounted rate for some Educational Therapists. You must pay ahead for any services your child utilizes in order to receive the discounted price. If you are interested in the plan please contact the office for information.

Unless other arrangements have been made, payment is expected at the time of service. We accept cash, checks and Visa and Master Card. There is a \$25 fee for returned checks.

Please note that these prices are subject to change without notice and are offered for current DLS clients only.



# Developmental Learning Solutions

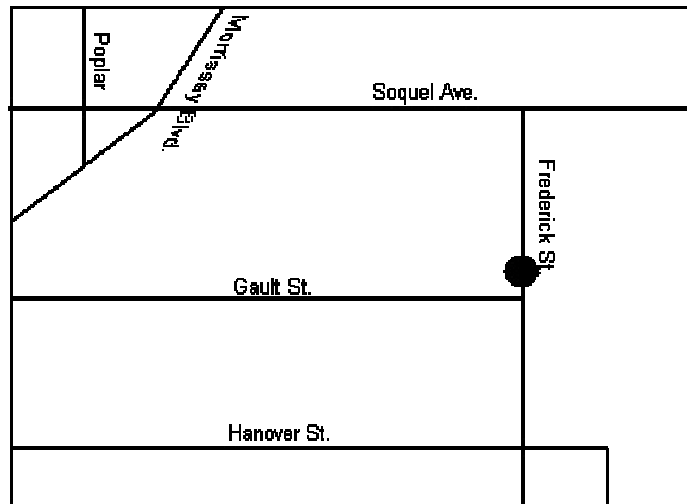
700 Frederick St. #204, Santa Cruz, Ca 95062

## Map and Directions

700 Frederick St., Suite 204

Santa Cruz, Ca 95062

(831) 429-5987



## From the North (San Jose)

- Merge onto CA-17 S toward Santa Cruz
- Merge onto CA-1 S toward Watsonville/Monterey
- Take the exit toward Morrissey Blvd.
- Turn Left onto Fairmount Ave.
- Turn Right onto Morrissey Blvd.
- Turn Left onto Soquel Ave.
- Turn Right onto Frederick St.

## From the South (Carmel)

- Take CA-1 N
- Take the Morrissey Blvd. exit
- Keep Left at the fork in the ramp
- Turn slight Left onto Morrissey Blvd.
- Turn Left onto Soquel Ave.
- Turn Right onto Frederick St.