LEVEL
ACADEMIC CONSULTING
"Leveling the field for all learners"

Reading Assessment Interview

Parent Information

Parent/Guardian Name: _____
Marital Status: _____
Address: _____
City:_____ State:_____
Zip: _____ Phone Number: _____
E-mail: _____

Child Information

Child's Name:_____
Age: _____ Date of Birth:_____ Male:____ Female: ____
School:_____ Grade:_____
Teacher:_____
Physician Name: _____
Physician Phone Number: _____

Prenatal History

Full term pregnancy? (40 Weeks) __ Yes __ No If no, how many weeks?_____

Were any medication(s) given during pregnancy? __ Yes __ No
If yes, what?_____

Did you have any illnesses during pregnancy? __ Yes __ No
If yes, what?_____
How many weeks into pregnancy?_____

Smoking during pregnancy? __ Yes __ No
Alcohol or drugs during pregnancy? __ Yes __ No

School History

Have any grades been repeated? __ Yes __ No If yes, which grade(s)? _____
Any MTSS/RTI?__ Yes __ No
What grade did it start?_____
Has it been/Was it effective?_____

Is your child in any special classes? __ Yes __ No
Has he/she ever been in any special classes? __ Yes __ No
Which classes? _____
Rate your child's current performance in the following subjects:
1 – above average 2 – average 3—below average
__ Reading __ Spelling __ Mathematics __ Comprehension __ Handwriting
__ Letter Formation __ Keeping numbers lined up when doing math problems
__ Letter Spacing __ Word spacing

Has your child had tutoring? __ Yes __ No
What subjects?_____
From who?_____

Please describe any behavioral concerns at school:_____
_____
_____

List special programing at school: __Reading program __Speech Therapy __IEP
__504 __Occupational Therapy __Other:
_____
_____
_____

Medical History

History of Allergies? __ Yes __ No
If yes, what? _____

History of Ear Infections? __ Yes __ No
If yes, when did they start? _____
Level of severity? __ Severe __ Moderate __ Mild
Both ears? __ Yes __ No
Tubes in ears? __ Yes __ No
If yes, when?_____
High fevers? (Above 104) __ Yes __ No

Current Medications:_____
_____
_____

Broken bones? __ Yes __ No
Explain:_____
_____

History of Physical Trauma? __ Yes __ No
Explain:_____
_____

History of Psychological Trauma? __ Yes __ No
Explain:_____
_____

Has a vision test been completed within the past 6 mo.: __Yes __No
Were glasses prescribed? __Yes __No
Where was test given?_____

Has a hearing test been completed within the past 6 mo.: __Yes __No
Where was test given?_____
Results? _____

Has an intelligence evaluation been completed within the past 6 mo.: __Yes __No
Who administered evaluation?_____
Results? _____

Has an occupational therapy evaluation been completed within the past 6 mo.:
__Yes __No
Are occupational therapy services currently being provided? __Yes __No
If yes: Where are services provided?_____
Occupational Therapist Name: _____

Has a speech therapy evaluation been completed within the past 6 mo.: __Yes __No
Are speech therapy services currently being provided? __Yes __No
If yes: Where are services provided?_____
Speech Therapist Name: _____

Has your child been evaluated for Attention Deficit Disorder within the past 6 mo.:
__Yes __No
Who administered evaluation?_____
Results? _____
Family history of ADHD?_____

Rate your child on the following items:
1 – Always 2- Frequently 3-Occasionally 4-Rarely 5-Never 6- Unknown

___ Hyperactive ___ Difficulty following verbal directions ___ Distracted
___ Poor ability to organize work ___ Short Attention Span ___ Fatigued
___ Poor peer group relationships ___ Frustrated ___ Impulsive
___ Emotional Problems ___ Variable School Performances ___ Awkward or Clumsy

For clients older than 15 years of age
Does the client consume alcohol or drugs?_____
Please describe frequency / type:_____
Does the client consume nicotine (cigarettes, chewing tobacco, etc)?_____
Please describe frequency / type:_____

Is there a biological family history of dyslexia or difficulties with reading?: __Yes __No
_____
_____

Communication
Primary Language spoken in the home: _____
Primary language spoken by the client:_____
Does the client use any alternative forms of communication?_____
Is the language content consistently appropriate?_____
Does the client use any unusual phrases?_____

Strengths
What are the client's strengths:_____
_____

What does the client like (reinforcers):_____
_____

What does the client like to do for fun?_____
_____

What has happen lately that has you interested in getting help?

_____
_____
_____
_____

How long has this been a concern?_____

Please describe family's priorities for assessment:_____

_____
_____
_____
_____
_____
_____

Anything else you'd like me to know:

_____
_____
_____
_____
_____
_____
_____
_____

Please come to assessment with copies of:
-Current IEP/504s
-Vision/heading assessment results
-Psychological testing results
-A sample of writing/average school work
-Any school reading scores for the past year
-Any other documents that you feel will help me understand your learners current academic performance strengths/weaknesses