BELLAVISTA
•S•E•E•K•
EDUCATION ASSESSMENT CENTRE

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www.bellavista.org.za

PLEASE ATTACH ALL PREVIOUS ASSESSMENT REPORTS

Date of submission _____ Date of completion _____

Please think carefully about your child's development and describe behaviours that are brought to mind when you answer these questions:

- Were these different from other children you know?
- Were there occasions when these behaviours made if difficult to cope as a family?
- Did you find solutions which helped to deal with any problem behaviours?

The questions are designed to assist in formulating a picture of your child and his/her development. Take time to think about the questions. Some may not apply to your child, but if they do, please answer as fully as possible.

Details of Child to be assessed

(kindly submit a photo of your child)

Personal			
Surname			
Full first name			
Date of birth		**ID Number**	
Age		**Gender**	
Home language			
Religion			
Present medication and dosage			
Street address			
Postal address			
Why are you seeking assessment for your child?			

Medical Aid Details	
Medical aid and contact no.	
Membership number	
Medical aid package	
Dependant code	

School History	
Current School	
Name of school	
School's telephone number	
Principal name	
Class Teacher	
Teacher's telephone number	
Teacher's email address	
Present grade	
Grades repeated	
Medium of instruction, e.g., Eng	
Do you give us permission to contact your current school?	

Schools Attended				
Facility	**Name**	**Month & Year of entry**	**Child's Age**	**Month and Year of exit**
Nursery School				
Primary School				
High School				

School readiness		
Was your child considered ready for GrR Primary School?	Yes ☐	No ☐
Was a school readiness assessment conducted?	Yes ☐	No ☐
If your child was considered not ready, what reasons were given?		
In which grade were the difficulties first noticed?		
Comment on the school your child is presently attending. How many children are there in his/her class? Does your child relate well to his/her teacher? Are you happy with the attention he receives?		

Parental Information	
Parent	
Title and surname	
First name	
ID number	
Present occupation	
Nationality	
Name of business	
Business address	
Business telephone number	
Cell phone number	
Home telephone number	
Email Address	
Residential Address	
Postal Address	
Previous occupations over child's lifespan	
Have any of these jobs necessitated long absences from home?	
Parent	
Title and surname	
First name	
ID number	
Present occupation	
Nationality	
Name of business	
Business address	
Business telephone number	
Cell phone number	
Home telephone number	
Email Address	
Residential Address	
Postal Address	
Previous occupations over child's lifespan	
Have any of these jobs necessitated long absences from home?	

Marital Status					
Single	Married	Divorced	Separated	Widowed	Deceased
☐	☐	☐	☐	☐	☐

If separated, to whom must documentation be sent?	Both ☐	Parent Only ☐	Parent Only ☐
<u>If divorced, who has legal custody?</u>		Parent ☐	Parent ☐
If divorced does the other parent have access and visiting rights		Yes ☐	No ☐
Is this child:	Biological ☐	Fostered ☐	Adopted ☐

Siblings (In Chronological Age)				
Name	**Age**	**School**	**Class**	**Academic progress**

Position of child to be assessed, within the family: _____

How do you "see" your child?

It is very important that each parent fill in this section separately as it contains valuable information.
This is not the place to discuss your present concerns (see page 8). Just describe your child as he/she appears to you.

Parent's Description

Parent's Description

Other significant person's description (Grandparent, AuPair, etc.)

Your child now – at home				
(Please select ☒ the correct answer)				
Sleep				
Restless ☐	Regular ☐	Nightmares ☐	Bedwetting ☐	Sleepwalking ☐
Eating				
Good appetite ☐		Fussy eater ☐		
Habits				
Thumb sucking ☐	Nail biting ☐	Twitching ☐	Other	
Does your child appear to concentrate for an extended period of time, e.g, playing, watching TV?			Yes ☐	No ☐
Do you have to continually repeat instructions?			Yes ☐	No ☐
Does your child get distracted easily?			Yes ☐	No ☐
How do you rate the following?				
Concentration	Good ☐	Average ☐	Poor ☐	
Activity level	Overactive ☐	Normal ☐	Poor ☐	
Talks	Too much ☐	Average ☐	Too Little ☐	
Fidgets	A lot ☐	A little ☐	Not at all ☐	
Socially:				
Does your child prefer to play alone?			Yes ☐	No ☐
Does your child like to have the company of friends?			Yes ☐	No ☐
Does your child interact well with friends?			Yes ☐	No ☐
What age group does your child prefer to play with?	Older ☐	Younger ☐	Both ☐	
How does your child interact with family members?				
How does your child interact with other adults?				
Present Concerns				
Please state person and/or organisation who made the referral, e.g., school, doctor, teacher, family friend or other)				

Please state your reasons for seeking help
Please give details of your concerns. What do you think are the reasons for these problems and what are the contributing factors?

Parent's Education	
Parent	
Primary Education	
High School	
Tertiary Education	
Parent	
Primary Education	
High School	
Tertiary Education	

Family History					
Comment on any factors you feel are significant within the family eg. physical and health or learning difficulties. Please elaborate where possible.					
Did either parent experience concentration difficulties as a child?					
Parent	Yes ☐	No ☐	Parent	Yes ☐	No ☐
Now, as an adult, do you find it difficult to sustain attention?					
Parent	Yes ☐	No ☐	Parent	Yes ☐	No ☐
Did either parent experience any kind of learning difficulties at school? Please specify.					
Parent	Yes ☐	No ☐	Parent	Yes ☐	No ☐
Did either parent or extended family member (brother, cousin, etc) experience a reading or spelling problem?					
What parent's side?	Yes ☐	No ☐	What parent's side?	Yes ☐	No ☐

Does anyone in the family have a speech, language and/or hearing problem?					
What parent's side?	Yes ☐	No ☐	What parent's side?	Yes ☐	No ☐
Is your child left handed? (select yes or no answer)				Yes ☐	No ☐
Is any other family member left handed?					
What parent's side?	Yes ☐	No ☐	What parent's side?	Yes ☐	No ☐
Has the child or the family ever experienced any trauma, e.g., Death of a loved one, divorce, hijacking, violence etc? Please give details.					

Family Relationships *(Please describe the following)*
Marital relationship
Relationship of child with parent
Relationship of child with parent
Relationship of child with siblings
Other significant role players

Discipline		
Who disciplines at home and how?	Parent ☐	Parent ☐
Is it consistent?	Yes ☐	No ☐
What discipline problems do you experience with your child? ***(Please specify below)***		

Assessments

Please state whether your child has had any previous assessment (e.g. psychological, educational) and if so, by whom and when? It is important for the various assessors to know what test have been done on your child. Some may not be repeated as they require a set period before retesting may occur.

Paediatrician			
Name and Surname			
Contact Number		**Consultation Date**	
Email Address			
Report Attached	Yes ☐	No ☐	
Reason			
Findings			
Medication			

Neurologist			
Name and Surname			
Contact Number		**Consultation Date**	
Email Address			
Report Attached	Yes ☐	No ☐	
Reason			
Findings			
Medication			

Psychiatrist			
Name and Surname			
Contact Number		**Consultation Date**	
Email Address			
Report Attached	Yes ☐	No ☐	
Reason			
Findings			
Medication			

Occupational Therapist			
Name and Surname			
Contact Number		**Therapy Date**	
Email Address			
Report Attached	Yes ☐	No ☐	
Is therapy currently underway?	If yes, name of Occupational Therapist / consulting professional		
	If no, termination date and reasons		
Recommendations			
Speech-Language Therapist			
Name and Surname			
Contact Number		**Therapy Date**	
Email Address			
Report Attached	Yes ☐	No ☐	
Is therapy currently underway?	If yes, name of Speech Therapist / consulting professional		
	If no, termination date and reasons		
Recommendations			

Physiotherapist or any other early intervention			
Name and Surname			
Contact Number		**Therapy Date**	
Email Address			
Report Attached	Yes ☐	No ☐	
Is therapy currently underway?	If yes, name of consulting professional		
	If no, termination date and reasons		
Recommendations			

Remedial Therapist			
Name and Surname			
Contact Number		**Therapy Date**	
Email Address			
Report Attached	Yes ☐	No ☐	
Is therapy currently underway?	If yes, name of Remedial Therapist / consulting professional		
	If no, termination date and reasons		
Recommendations			

School Psychologist Service			
Name			
Contact Number		**Therapy Date**	
Email Address			
Reason			
Findings			

Do you give us permission to contact the above therapists to the (Please select Yes or No)	**YES** ☐	**NO** ☐

Developmental History

Pregnancy and Birth			
Please select the appropriate column **and comment**.			
PREGNANCY	**Yes**	**No**	**Comment**
1. Were there any miscarriages/still births?	☐	☐	
2. Was your baby planned?	☐	☐	
3. How long had you been married/ in a relationship when the baby was born?	☐	☐	
4. Did either parent have physical and/or emotional problems during pregnancy,e.g., flu, infections, unusual tension or trauma?	☐	☐	If so, please elaborate_____
5. Were any medications taken during the pregnancy?	☐	☐	If yes, what were they? _____
6. Were X-rays and scans taken?	☐	☐	How many? _____
7. Smoked during pregnancy?	☐	☐	
8. Drank during pregnancy?	☐	☐	
BIRTH	**Yes**	**No**	**Comment**
1. Please state whether your baby was premature, full term or post-mature	☐	☐	
2. Where was the baby born (name hospital where appropriate)			
3. Was there a prolonged labour?	☐	☐	
4. Was there any foetal distress?	☐	☐	
5. Forceps used?	☐	☐	
6. Cord around neck?	☐	☐	
7. Caesarian section? Why?	☐	☐	
8. Was an incubator used?	☐	☐	If yes, for how long? Could parents touch baby in the incubator?
9. What was the Apgar rating?	/	/	At 1 minute? _____ At 5 minutes? _____
10. What was the birth weight?	/	/	
11. Were there breathing difficulties?	☐	☐	Was oxygen administered?
12. Initial jaundice? Was the baby put under lights?	☐	☐	For how long? _____
13. Did the parent and baby go home together? If not, did the parent visit daily?	☐	☐	If no, how long did baby remain in hospital? _____
14. Did the parent breast feed at hospital or express milk to take it into the hospital?	☐	☐	
15. Post natal depression?	☐	☐	If yes, for how long? _____ Was any treatment necessary? _____ Were there any problems in bonding?_____

Infancy			
Did your baby experience	**Yes**	**No**	**Comment**
1. Feeding problems	☐	☐	Who advised? _____ How many formulas tried? _____ Did you stick rigidly to 4 hour feeding or did you feed on demand? _____
2. Colic	☐	☐	Was there excessive crying? _____ Did it last 3 months or was it longer? _____ How did this make you feel? _____
3. Disturbed sleep patterns	☐	☐	
4. Eczema, asthma, other allergies	☐	☐	
5. Did you notice that at times your baby seemed to be floppy or very stiff?	☐	☐	
6. When did you start toilet training?	/	/	
7. When was your child dry during the day?	/	/	
8. When was your child dry during the night?	/	/	

Baby's behaviour (please select appropriate answers)						
Difficult ☐	Content ☐	Sleepy aggression ☐	Head banging ☐	Temper tantrums ☐	Rocking ☐	Breath holding ☐

Emotional Development			
In his first three years, did your child :	**Yes**	**No**	**Comment**
1. Suck a dummy?	☐	☐	
2. Bite his/her nails?	☐	☐	
3. Suck his/her thumb?	☐	☐	
4. Have a special toy/blanket?	☐	☐	
5. Masturbate heavily?	☐	☐	If yes, how did you deal with this?
6. Hair pluck? Where?	☐	☐	If yes, where?
7. Head bang?	☐	☐	
8. Have specific fears?	☐	☐	What are they? Is there a realistic origin?
9. Have nightmares? Does the child sleep with the light on?	☐	☐	
10. Have tantrums?	☐	☐	If yes, how do you deal with these?
11. Bed-wetting problems?	☐	☐	In the early hours or later? Is there any thrashing about in bed?
12. Soiling problems?	☐	☐	

Comment on any of the above habits that still continue			
Are these, in your opinion, related to school? If not, what do you think causes this at home?			
Is your child easily frustrated?		Yes ☐	No ☐
Is he overly sensitive or emotional?	Overly Sensitive ☐	Emotional ☐	

Medical History			
Please give the following details:			
Details	**Name**	**Date**	**Comments** (including changes in behaviour)
Childhood illnesses			
Operations			
Allergies			

Has your child had a *thorough medical examination recently by a paediatrician*?	Yes ☐	No ☐
If yes, please fill in the following		
By Whom		
When		
What were the findings?		

Record of Medication			
Year	**Type of medication and dosage**	**Prescribed by**	**Behavioural changes**

Please attach reports for the below testing; failing to do so may result in a delay regarding assessments.

Visual System - EYE TEST

By Whom	
Date	
Findings	

Does your child:	Yes	No	Comment
Have a diagnosed visual defect?	☐	☐	How has this been treated/corrected?
Wear glasses?	☐	☐	If yes, please ensure that they are brought with to the assessments
Seem to have difficulty following a moving object?	☐	☐	
Make reversals when copying?	☐	☐	
Appear to be sensitive to light/sunlight?	☐	☐	
Resist having eyes closed/covered?	☐	☐	
Blink eyes continuously?	☐	☐	
Are eyes continually red/watery?	☐	☐	
Tend to work with head close to the table?	☐	☐	
Become excited/confused when confronted by a variety of visual stimuli/objects?	☐	☐	

Motor Milestones

Approximately when did the following occur?	Age/Comment
(If you cannot recall exact ages, did it appear to be the same as other children or earlier or later?)	
Smile	
Hold head up	
Roll over	
Sit by himself without help	
Crawl	In what way? _____ For how long? _____
Walk	
Ride a tricycle	
Ride a bicycle without "fairy" wheels	
Did your child use a walking ring?	Yes ☐ No ☐ If yes: At what age did the child start using it? _____ At what age did the child stop using it? _____ For how long each day was he/she in it? _____
Did your child use a jolly jumper?	Yes ☐ No ☐
Does your child enjoy jungle gym equipment and other outdoor activities?	Yes ☐ No ☐

Functional Tasks:	Yes	No	Age/Comment
Does your child dress/undress him/herself?	☐	☐	
Does your child experience difficulty with shoelaces or buttons, putting on a T-shirt or sweater?	☐	☐	
Is your child a messy eater?	☐	☐	

Where does your child eat?	At the table, ☐ with the family ☐ or alone? ☐ At what time? _____		
Does your child bath independently?	☐	☐	
Brush teeth independently?	☐	☐	
Use the toilet independently?	☐	☐	
Sensorimotor History:			
If there have been noteworthy changes or alterations in the following behaviours, please comment on these as this could help the therapist.			
Tactile sensation - does your child :	**Yes**	**No**	**Comment**
Dislike being touched?	☐	☐	
Prefer to touch than to be touched?	☐	☐	
Dislike being cuddled/hugged?	☐	☐	
Seem irritable when held?	☐	☐	
Have a strong need to touch people, objects and/or animals?	☐	☐	
Seem easily irritated or enraged when touched by siblings or playmates?	☐	☐	
Frequently push/bump other children (eg. when standing in a line)?	☐	☐	
Seem to pick fights at school (eg. standing in line, on the playground)?	☐	☐	
Isolate him/herself from other children?	☐	☐	
React negatively to the feel of new clothes/labels on collars/textures of clothes?	☐	☐	
Seem unaware of excessive temperature (eg. wear a sweater in summer?)	☐	☐	
Dislike having hair and/or face washed?	☐	☐	
Dislike having a haircut?	☐	☐	
Object strongly to having his/her nails cut?	☐	☐	
Dislike being dirty or sticky? Will he/she play with clay, mud, etc.?	☐	☐	
Avoid taking off his/her shoes and walking barefoot on grass, sand, etc.?	☐	☐	
Seem extremely brave or almost unaware of painful experiences, e.g, stitches, injections, bruises, cuts?	☐	☐	
Taste and Smell - does your child :	**Yes**	**No**	**Comment**
Identify odours?	☐	☐	
Ignore/react strongly to bad smells?	☐	☐	
Is your child overly sensitive to different smells?	☐	☐	
Refuse to try new foods?	☐	☐	
Dislike food or certain textures (eg, rough, food that needs to be chewed, sherbet)	☐	☐	
Only eat foods that are smooth with no lumps?	☐	☐	
Act as if all foods taste the same?	☐	☐	
Explore the environment by tasting/putting everything into his/her mouth?	☐	☐	
Refuse to co-operate at the dentist?	☐	☐	
Dislike brushing teeth?	☐	☐	

Vestibular - does your child :	**Yes**	**No**	**Comment**
Enjoy being rocked?	☐	☐	
S when you playfully throw/threw up in the air and catch/caught?	☐	☐	
Seem fearful of space, eg, going up and down stairs, escalators, lifts, etc.?	☐	☐	
Appear to be clumsy and often bump into things and/or fall down?	☐	☐	
Enjoy fast moving, rolling, spinning movements and/or rides?	☐	☐	
Tend to avoid balance activities such as climbing over chairs, balance beams?	☐	☐	
Avoid jungle gyms/ outdoor climbing activities?	☐	☐	
Dislike riding on an adult's shoulders?	☐	☐	
Get car sick easily?	☐	☐	
Are your child's movements slow, plodding and/or deliberate?	☐	☐	
Co-ordination - does your child :	**Yes**	**No**	**Comment**
Seem to be in perpetual motion from the time he/she wakes until bedtime?	☐	☐	
Manipulate small objects with his/her fingers?	☐	☐	
Seem accident prone, ie, have frequent bumps, bruises, scratches?	☐	☐	
Eat in a sloppy manner?	☐	☐	
Does he/she use a spoon, knife, fork correctly?	☐	☐	
Have difficulty with pencil activities, eg, colouring in, outlining?	☐	☐	
Appear to tire easily?	☐	☐	
Has your child established a consistent hand dominance?	☐	☐	**If yes, which hand does he/she prefer?**
Seem to ignore one side of the body?	☐	☐	**If yes, which side?**
Appear to have difficulty with tasks requiring a sequence of movements, e.g., dressing?	☐	☐	
Have noticeable tongue movements when concentrating hard?	☐	☐	
Appear to be stronger or weaker than other children of a similar age?	☐	☐	
Frequently grasp objects too loosely or too tight	☐	☐	
Play - does your child :	**Yes**	**No**	**Comment**
Play in a constructive or destructive manner?	☐	☐	
Play out of his/her own volition/initiative or does he/she need to be constantly guided/led?	☐	☐	
Organised his/her approach to an activity/task or does he/she work in a haphazard manner?	☐	☐	
Use the toys/equipment appropriately for his/her age?	☐	☐	
First attempt the game (yes) or rather watch others before attempting it him/herself (no)?	☐	☐	
Are your child's movements flowing or is there poor judgement of timing?	☐	☐	
First make something and only thereafter decide what it is?	☐	☐	

Is your child's play repetitive or varied?	☐	☐	
take risks or does he/she prefer to "play it safe"	☐	☐	
Any other important aspects of development which you feel would assist the therapist:			

Please ensure that your child wears "takkies", running shoes or closed shoes for the Occupational Therapy Assessment

Auditory System - HEARING TEST	
By Whom	
Date	
Findings	

Does your child:	**Yes**	**No**	**Comment**
Seem to hear sounds unnoticed by other children/adults?	☐	☐	
Seem to be very sensitive to sounds, eg, refrigerator, fluorescent lights, heaters?	☐	☐	
Seem confused as to the direction from which a sound comes?	☐	☐	

Speech-Language Milestones

Medical History

Has your child suffered from ear infections?	**Never**	**Seldom**	**Frequently**
0 – 3 years	☐	☐	☐
3 – 6 years	☐	☐	☐
Above 6 years	☐	☐	☐

When was the last ear infection?			
By whom was it treated and how? (complete below)			
Whom		**How**	

Is there a speech problem within the family? Yes ☐ No ☐ Please give full details.

Speech-Language Milestones (select correct answer)		
Did your baby cry at birth?	Yes ☐	No ☐
Was s/he an abnormally quiet baby? (not just contented)	Yes ☐	No ☐
Did your baby respond to sounds?	Yes ☐	No ☐
Was s/he able to imitate sounds?	Yes ☐	No ☐

Please give approximate dates, e.g., 11 months) to the following:	**Dates**
Babbling	
First Words	

Sentences		
At Present		
Does your child show understanding when spoken to?	Yes ☐	No ☐
What makes you certain of this?		
How do you rate your child's vocabulary in comparison with others of his age?		
When your child speaks		
Does he express himself fluently?	Yes ☐	No ☐
Use long sentences?	Yes ☐	No ☐
Deploy a good vocabulary?	Yes ☐	No ☐
Is s/he easily understood by others?	Yes ☐	No ☐

RELEASE FORM

PREVIOUS ASSESSMENT REPORTS SHOULD ACCOMPANY THIS QUESTIONNAIRE.

ONLY IN SIGNING THIS FORM YOU GIVE US PERMISSION TO CONTINUE WITH THE PROCESS

In order that we can provide you and your child with the maximum assistance, it is important that we have as much information as possible concerning the developmental history of your child. This includes information concerning difficulties experienced by your child as well as results of any medical, psychological or any other professional testing. You are entitled to seek an assessment even if your child is currently in therapy with another therapist; however, we suggest that to open lines of communication between the professionals only benefits the child being assessed.

To obtain reports on the results of any tests, or to forward any information, we require your permission in writing. We assure you that all information on your family and your child will be kept strictly confidential. It is important for the assessor to know what tests have been done on your child as some may not be repeated, or they may require a set period before retesting may occur.

Unless estranged and there is evidence (please provide) that one of the parents does not need to sign consent, both parents must sign below.

1)	I/we hereby authorise the release of any information with regard to _____ (name of pupil) to Bellavista S.E.E.K.
2)	I/we hereby declare that all the information provided is to the best of my knowledge, accurate and true.

SIGNED:	_____	in the capacity of parent or guardian.	
PARENT FULL NAME:	_____	**DATE:**	_____
SIGNED:	_____	in the capacity of parent or guardian.	
PARENT FULL NAME:	_____	**DATE:**	_____

PAYMENT REQUIREMENTS

Payment of R900.00 administrative fee

Payment by EFT to:	Bellavista School
Bank:	Standard Bank
Branch:	Rosebank Branch
Branch Code:	004305
Account Number:	001986686
Please reference your payment as follows:	Child's name / admin fee

Proof of payment to be provided

Teacher Checklist

Please share with us some of your observations of the child's general learning and reading behaviours.

Area	Characteristics / Behaviour	Yes/ No
General / Organisational	• Does the child forget the right equipment for a task? • Does the child process instructions slowly/one at a time? • Does the child have concentration difficulties? • Does the child struggle to carry out tasks in order? • Does child struggle to remember concepts from one lesson to the next?	Yes No Yes No Yes No Yes No Yes No
Listening Comprehension	• Does the child listen well? • Does the child participate in oral discussion? • Is oral language stronger than written language?	Yes No Yes No Yes No
Literacy / Reading	• Does the child dislike reading? • Does the child lose his/her place frequently? • Does the child have poor letter-sound correspondence? • Does the child confuse words that look similar? • Does the child confuse position of letters (e.g. was/saw)? • Does the child reverse/inverts letters (e.g. b/d, n/u)? • Does the child leave out words? • Does the child sound out words, making reading slow?	Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No
Writing	• Does the child struggle to sequence work? • Does the child have good ideas, but can't write it down? • Are there many crossings out? • Is the child's written work incomplete? • Does the child write slowly? • Does the child have poor handwriting? • Does the child reverse/inverse letters (b/d, m/w, p/q)? • Is the writing poorly poorly spaced? • Does spelling show poor sound-symbol correspondence?	Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No
Maths / Numeracy	• Does the child have difficulties in mental math work? • Is there a problem remembering math times tables? • Does the child confuse/reverse numbers (e.g. 6/9, 3/5)? • Do reading difficulties hinder understanding of questions?	Yes No Yes No Yes No Yes No
Attitude to learning / classroom tasks	• Does the child prefer oral work more than reading/writing? • Does the child have low self-esteem re schoolwork? • Has the child developed behaviour like clown/ withdrawn? • Does the child copy from others instead of trying? • Is the child tired often because of extra effort? • Does the child perform unevenly from day to day?	Yes No Yes No Yes No Yes No Yes No Yes No
Identify specific difficulties and average / high ability / knowledge / skills not mentioned above that the child may experience in the classroom	Identify specific difficulties not mentioned above that the child may experience in the classroom	

Adapted from: Phillips, Kelly and Symes (2013: 49 – 50)