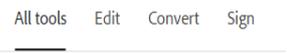


Background Questionnaire Primary

Thank you for downloading and taking the time to fill in this questionnaire. If you have trouble following the instructions, please contact us at careen.learning2succeed@gmail.com or call 0771 747 3048.

Instructions on how to fill in using Adobe Acrobat Reader DC

- 1) When you have downloaded the questionnaire to your PC, open it. It should automatically open in Adobe Acrobat Reader DC if this is installed on your computer.

- 2) Click "All tools":  Then click "Fill and Sign"  Fill & Sign

- 3) Now you can enter information into the questionnaire.

For entering text, click this button  X ✓ • □ -

then using the mouse cursor, click where you want to enter text and this box will appear:



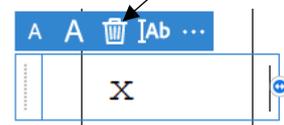
Now enter the text then click Esc on the keyboard when done.

Please note: to fill in a box with text on more than one line, press Enter on the keyboard to start the next line.

- 4) For some parts of the questionnaire with boxes, as seen below, please type an X in the applicable box for each question. Please click the **middle** of the box until the cursor comes up, then type an X

Never	Sometimes	Frequently	Always	Comments...
				

If you make a mistake, don't worry! Simply click the bin button to remove the X



- 5) To navigate to the next page or back to the previous page, click these arrows at the right-hand side of the page. The page number you are currently on will be displayed:



Background Questionnaire Primary



Child's Name:		Date of Birth:	
Gender		Age at Assessment:	
Address:		School:	
Post Code:		School Year:	
Parents Phone:			

Please summarise your child's current situation:

Why have you chosen to have an assessment at this time?

Terms and Conditions.

Please note!!! The assessment will be carried out in two parts both taking place online using Microsoft Teams, or Zoom. Please read all the following:

For the assessment to take place successfully, the following is required:

- A quiet room with no disturbances throughout the duration of the assessment
- A laptop or desktop computer with a webcam, microphone, speakers or headphones, with Microsoft Teams software, and Zoom installed. Please don't use a phone or tablet as the test materials used will not appear at the correct size
- A reliable broadband internet connection

Please be aware that if all of the above are not available, the assessment will not be possible. If during assessment the internet connection becomes unstable, the assessment will need to be terminated.

Background Questionnaire Primary



Family and Medical History

It can be helpful to know about your child's background and development. Please consider the following questions but leave blank any answers to which you would rather not respond or have no recall. Please send the completed questionnaire to info@learning2succeed.co.uk, with any further information such as previous reports you may have.

1. Ages of any siblings (If applicable)	
2. Do any siblings have similar difficulties?	
3. Is there any history of reading/spelling/speech difficulties in close or extended family?	
4. Were there any problems during pregnancy and / or birth?	
5. How is their general health?	
6. Are they prescribed any medication?	
7. Did they reach your developmental milestones as a toddler? E.g. crawling, sitting, walking, co-ordination, weaning. If not please give details.	
8. Has your child had any accidents / injuries/ operations?	
9. Do they have any hearing difficulties?	
10. Were they absent from the routine hearing tests at school?	
11. Is English the only language spoken at school or at home?	
12. Is English their first language? If not...	
a. What is your child's dominant language?	
b. How long have they been learning English?	
c. how long have they been speaking English?	
d. Is your child's education presented in English?	
e. How long has your child resided in an English-speaking country?	
13. Was your child late learning to talk?	
14. Are there any difficulties with articulation, pronunciation, or word-finding?	
15. Have they received speech therapy? If yes, when and how long for?	
16. Has your child had any previous educational assessments? E.g. educational psychology, speech and language, occupational therapy, or screening tests for SpLD.	

Background Questionnaire Primary



School History

1. At what age did your child start school?	
2. At what age did suspect there might be a problem?	
3. Is your child left or right-handed?	
4. Did they have trouble deciding on a dominant hand?	
5. Describe your child's early progress with reading/writing/handwriting/numeracy	
6. Do they usually write, have a scribe or word process in class?	
7. What is their experience of revision?	
8. Do they have an educational support or learning plan?	
9. Have there been any extended periods of absence from school?	

SAT Results and Exam Arrangements

<u>Subject</u>	<u>Result</u>	<u>Exam Arrangements (if applicable)</u>

Favourite Subjects

Please tell us your child's **most** and **least** favourite subjects, under the comments section explain what they like and dislike about these subjects:

<u>Subjects</u>	<u>Comments</u>

Background Questionnaire Primary



Section 1: Questions about your Child Please mark an X in the appropriate box

Questions	Never	Sometimes	Frequently	Always	Comments...
Does your child:					
ADC 1. Have difficulties with self-care tasks, such as tying shoelaces, fastening buttons and zips?					
ADC 2. Have difficulty eating without getting dirty?					
ADC 3. Have difficulty learning to ride a bike compared to their peers?					
ADC 4. Have difficulties with playing team games, such as football, volleyball, catching or throwing balls accurately?					
ADC 5. Have difficulty writing neatly (so others can read it)?					
ADC 6. Have difficulty writing as fast as their peers?					
ADC 7. Bump into objects or people, trip over things more than others?					
ADC 8. Have difficulty playing a musical instrument (e.g. violin, recorder)?					
ADC 9. Have difficulties with organising/finding things in their room?					
ADC 10. Have others comment about their lack of coordination or call them clumsy?					

** The above questions are taken from The Adult Developmental Coordination Disorder/ Dyspraxia Checklist (ADC) for Further and Higher Education (Kirby and Rosenblum, 2008)

Background Questionnaire Primary



Further Questions	Never	Sometimes	Frequently	Always	Comments...
Does your child:					
BQ 1. Feel behind in reading compared to those of the same age?					
BQ 2. Memorise stories from the pictures rather than the written text?					
BQ 3. Forget or confuse small abstract words? E.g. 'was' and 'were'					
BQ 4. Mispronounce words when reading?					
BQ 5. Read slowly or hesitantly?					
BQ 6. Have difficulty keeping on the lines when writing?					
BQ 7. Have difficulty showing maths steps?					
BQ 8. Have trouble remembering the days of the week?					
BQ 9. Have difficulty telling the time?					
BQ 10. Have difficulty understanding time intervals? E.g. 10 minutes or 1 hour					
BQ 11. Write letters, numbers or symbols in the wrong order?					
BQ 12. Find learning new vocabulary hard?					
BQ 13. Struggle to remember new vocabulary from one day to the next?					

Background Questionnaire Primary



Further Questions Does your child:	Never	Sometimes	Frequently	Always	Comments...
BQ 14. Find it hard to recite nursery rhymes?					
BQ 15. Find it difficult to remember the order things have happened in a day?					
BQ 16. Get distracted by background noise?					
BQ 17. Have a poor concentration span for reading and writing?					
BQ 18. Find it hard to concentrate in the classroom?					
BQ 19. Find it hard to concentrate at home?					
BQ 20. Struggle to get organised for school? E.g. getting books ready, forget PE kit					
BQ 21. Have difficulty maintaining eye contact					
BQ 22. struggle adjusting to the school environment?					
BQ 23. Have difficulty expressing their feelings					
BQ 24. Display repetitive behaviours such as tapping, chewing non-food items?					
BQ 25. Undertake self-soothing activities e.g. rocking					

Visual History Questionnaire

The following questions provide information on visual history, which helps in putting any reports of current visual difficulties into context.

QUESTIONS	RESPONSES	NOTES
<p>1. Have you been prescribed and advised to wear any optical prescription lenses (i.e. glasses or contact lenses)? if YES then :</p> <p>1a. Are these required for distance vision (e.g. television), near vision (e.g. reading), or both?</p> <p>1b. Do you wear your glasses / contact lenses as advised?</p> <p>1c. Do you have your glasses / contact lenses with you today?</p>	<p>(Y/N)</p> <p>(Dist / Near / Both)</p> <p>(Y/N)</p> <p>(Y/N)</p>	<p>If correction prescribed and normally worn for near work, then it should be worn for SpLD assessment</p>
<p>2. How long ago was your last sight-test or eye test by an optometrist ("optician") — less than two years ago, more than two years, NEVER)?</p>		
<p>3. Have you ever used coloured overlays or precision-tinted lenses? if YES then :</p> <p>3a. Who recommended and provided these?</p> <p>3b. Why were they recommended?</p> <p>3c. Did they help? — if YES, in what way?</p> <p>3d. Do you still use them? — if NO, why not?</p>	<p>(Y/N)</p>	
<p>4. Have you ever had hospital treatment for a problem with your eyes or vision? for example ... — wearing a patch for a 'lazy eye' (amblyopia)? or — wearing glasses or having exercises to help correct a 'turn' in your eye (squint)? or — any other condition?</p>	<p>(Y/N)</p> <p>(if Y, please comment here)</p>	

Background Questionnaire Primary



Visual Difficulties Questionnaire (VDQ)

The VDQ requests simple yes/no answers to a few questions about symptoms and signs involving FEEL (visual discomfort, Q1-3), SEE (visual disturbance Q4-7), DO (behaviour Q8-9), and one general question (10) about any other experience. Please mark an X in the appropriate column for each question.

QUESTIONS NB: The emphasis on the word often in questions 1-9, which is deliberately intended to identify when a symptom occurs frequently. Therefore, the individual should be advised to answer NO if reported symptoms would be considered infrequent (e.g. rarely, occasionally, sometimes, <2-3 times per month).	NO: this does not happen often	YES: this does happen often
<u>Questions about symptoms and signs involving “FEEL” (visual discomfort)</u>		
1. Do you often get headaches when you read or study?		
2. Do your eyes often feel sore, or gritty, or watery?		
3. Does reading from white paper or from a bright screen often feel uncomfortable?		
<u>Questions about symptoms and signs involving “SEE” (visual disturbance)</u>		
4. Does print often appear blurred, or go in and out of focus, when you are reading?		
5. Does the print, or book, or screen, often appear double when you are reading?		
6. Do words often seem to move or merge together when you are reading?		
7. Do objects in the distance often appear more blurred after you have been reading?		

Background Questionnaire Primary



QUESTIONS NB: The emphasis on the word often in questions 1-9, which is deliberately intended to identify when a symptom occurs frequently. Therefore, the individual should be advised to answer NO if reported symptoms would be considered infrequent (e.g. rarely, occasionally, sometimes, <2-3 times per month).	NO: this does not happen often	YES: this does happen often
<u>Questions about symptoms and signs involving “DO” (visual behaviour)</u>		
8. Do you often have to screw up your eyes to see more clearly when you are reading?		
9. Do you often move your eyes around or blink to make things clearer or more comfortable when you are reading?		
<u>General question</u>		
10. Do you experience any other problems with your vision that interfere with your ability to read or study? If YES then describe:		

** The above questions are taken from the SASC Visual Difficulties Screening Protocol June 2025

Background Questionnaire Primary



Activities

Please give named examples of activities that your child enjoys

Creative e.g. Sporting e.g. Computers e.g. Musical e.g. Practical e.g.	Active e.g. TV e.g. Artistic e.g. Social e.g.
Do they have any hobbies or belong to any clubs?	

Background Questionnaire Primary



Please read the declarations below carefully before signing and dating it.

Assessment data and any resulting reports will be stored securely for 6 years after your child's 18th birthday. This is for Learning2Succeed to fulfil its legal obligations and for auditing purposes. For further information please refer to the Learning2Succeed Privacy Policy on the website by going to this web address: <https://www.learning2succeed.co.uk/terms-conditions>

The information I have given on this form is complete and accurate to the best of my knowledge and belief.

There may be personal information that you have shared with us in this questionnaire, to assist in the diagnostic process, but that you would prefer not to be included in the report. Please mark this part with a * and then bring it to our attention.

I consent to personal data being entered onto the Riverside Insights Online Platform. To view the Riverside Insights Privacy Policy with regards to how they store your data, go to this link: https://info.riversideinsights.com/privacy-assessment_policy

I consent to personal data being stored electronically by Learning2Succeed. I understand that this information will not be shared with any third party unless I have given my explicit consent.

If the report is funded by a third party e.g. Access to Learning Fund or Workplace, I give my consent for the final report to be shared with the funding body of this assessment.

I agree to allow Learning2Succeed to retain my details for the purpose of sending occasional business updates. Learning2Succeed will not share your information with a third party.

By printing the parent or guardians name below, they consent for the information given to be used in the final report.

NB: Sign your name by choosing "Add signature" from the left of the page. Now you can type your name. Click "Apply". Now click in the Name box to insert your name.

Please ensure that a parent or guardian signs this form

Name:	Date:
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