The Therapy Path

7 Balsam Street South, 2nd floor
Timmins, Ontario
P4N 2C7

Phone (705) 267-2266
Fax (705) 267-2270
www.therapypath.com

First Step to Literacy Questionnaire

Child's Name: _____ Address: _____
D.O. Birth _____ Age: _____ City: _____
Parents/Guardian Names: _____ Postal Code: _____
Current date: _____ Phone #: _____

Past Medical and Surgical History

- Hearing: Year tested _____ Results _____
- Vision: Year tested _____ Results _____
- Problems with Diet: No ☐ Yes ☐ _____ Sleep: No ☐ Yes ☐ _____ Allergies: No ☐ Yes ☐ _____
- Prior injury No ☐ Yes ☐ _____
- Prior or current medical condition No ☐ Yes ☐ _____
- Prior or current medications No ☐ Yes ☐ _____

Educational History

- Attendance record _____ absent days per year
- Conduct/behaviour _____
- Ability to work in structured environment _____

Social History

- Social interests _____
- Preferred play activities _____

Communication Skills

- Has your child been assessed by a Speech Language Pathologist No ☐ Yes ☐
- Does your child have any communication difficulties? Articulation __ Language __
  Comment: _____
  _____

Pre Literacy Skill

- Does your child pay attention when you read a story? No ☐ Yes ☐ _____
- Does your child remember parts of the story after it was read ? No ☐ Yes ☐ _____
  _____
- Can your child identify familiar logo's (STOP, McDonalds, Kellogg's...)? No ☐ Yes ☐
- Can your child recognize his/her name? No ☐ Yes ☐
- Can your child write his/her name? No ☐ Yes ☐
- Can your child sing the letters of the alphabet? No ☐ Yes ☐
- Can your child identify the letters of the alphabet? Yes, all___ Some___ No___
- Other than his name, how many words can your child read? None__ Less than 10__ More than 50__
- Other comments: _____
  _____.