CITY SCHOOL DISTRICT OF ALBANY

FBA PARENT/GUARDIAN INTERVIEW FORM

|  |  |
| --- | --- |
| Date Initiated (Mailed):       | Date of Completion:       |
| Student:       | Student ID #:       |
| Responding Parent (Guardian) Name(s):       |
| Staff Assisting with Form Completion (Name/Title):       |
| School:       | Grade:        | Age:       |

*Check type of parent contact*: phone interview: [ ]  meeting: [ ]  mail: [ ]

Parent (Guardian) email:       Best contact number:

**Problem Behavior**: Please describe the behavior that your child is exhibiting currently that you are most concerned about (at school and/or at home).

Behavior:

1. Who lives in your household?

1. What are your child’s interests? (How does your child like to spend free time? What do they like to do at home? What do they like to do with friends or in the community?)

1. Describe your child’s strengths. (What are they good at? What is their personality like? What is he/she like at home?)

1. How does your child feel about school?

1. Has your child always felt this way? Explain.

1. Thinking of the behavior you listed above, are there any warning signs that your child exhibits indicating that the behavior is about to occur? (E.g., becomes restless, agitated, withdrawn, begins to speak loudly, changes in mood, etc.)

1. Are there good days and bad days? Good times of day and bad times of day? If so, does there seem to be a pattern?

1. What tends to "set-off" the identified behavior? What is typically happening when the behavior occur? (E.g., told not to do something, denied an item or activity, a change in routine, etc.)

1. With whom is the behavior most/least likely to occur?

1. Do any of the following conditions affect the behavior? *Please check*

Being ignored [ ]  Difficult task [ ]  Stern reprimand [ ]

Change in routine [ ]  Disruption of favorite activity [ ]  New environment [ ]  Other:

1. Is the student currently taking any medications? Yes [ ]  No [ ]
2. Has the student had a medical and/or psychiatric evaluation? Yes [ ]  No [ ]
3. Please list medications, doses and diagnosis:

1. What is your child’s daily routine? (What time does he/she get up in the morning? go to sleep? do homework? etc.) Does your child have any sleep/eating issues?

1. Are any community agencies involved with your child / family? If so, please identify in the boxes below.

|  |  |  |  |
| --- | --- | --- | --- |
| AGENCY | CONTACT PERSON | SERVICES PROVIDED | REASON FOR INVOLVEMENT |
|       |       |       |       |
|       |       |       |       |

1. Have there been any significant events / changes within the family (example - divorce, change in living arrangements, incarceration, loss of job)? If yes, please describe:

1. What interventions do you think would help your child have a more positive experience in school?

1. Developmental History – did your child experience any issues / delays in the following areas? If yes, please explain.

|  |  |  |
| --- | --- | --- |
|  |  | Comment/Describe |
| Language Development Delay– speaking, communication | Yes [ ]  No [ ]  |       |
| Motor Skills Delay– crawling, walking | Yes [ ]  No [ ]  |       |
| Elevated blood lead levels? | Yes [ ]  No [ ]  |       |
| Head injury? | Yes [ ]  No [ ]  |       |
| Seizures? | Yes [ ]  No [ ]  |       |
| Significant / Chronic Medical Problems / Illnesses or Injuries? | Yes [ ]  No [ ]  |       |
| Severe physical or emotional trauma? | Yes [ ]  No [ ]  |       |
| History of mental illness in the family? | Yes [ ]  No [ ]  |       |
| History of substance abuse in the family? | Yes [ ]  No [ ]  |       |

1. OTHER COMMENTS: