Parent Questionnaire

CHILD

Full Name: ____________________

Home Address Street ____________________

City ____________________ State __________ Zip __________

Home Phone ____________________ Date of Birth ____________________

Who is completing this parent questionnaire?

_________ Mother _________ Father _________ Other Relative

_________ Guardian ______Caregiver ______Other

FAMILY

Mother Name ____________________

Home Address Street ____________________

City ____________________ State __________ Zip __________

Home Phone ____________________ Cell ____________________

Place of Employment ____________________

Description of Occupation ____________________

Father Name ____________________

Home Address Street ____________________

City ____________________ State __________ Zip __________

Home Phone ____________________ Cell ____________________

Place of Employment ____________________

Description of Occupation ____________________

____

Other Family Information

With whom has the child lived for most of the past year?

____Mother _____Father _____Both _____Guardian ______Other

Other children in the family-How many older? ______ How many younger? ____

Please list with ages____________________

____

Other people living in the household____________________

____

What language's) are spoken at home? _____ English _________Other

If other please list.____________________

Any special custom/ celebration or practices we should be aware of:

____

____

Have there been any recent changes in routine/ family structure that may impact your child's behavior: ____________________

____

Other Family Information Continued

Do you have any pets? Please list.______________________________

____

Parent involvement: Please indicate if you are interested in volunteer opportunities at the center.

______brat fry ______chaperone field trips ____coordinator for fundraisers

______other

CHILD CARE HISTORY

Has your child attended preschool/ child care before? ______ Yes _____No

If yes, for how long? _____6 months _____1 year

_____2 years _____more than 2 years

MEDICAL HISTORY

Child's Health Since Birth

Has your child ever had any major injuries or hospitalizations?

If yes, please explain______________________________

____

Does your child have any allergies? _________ Yes ______ No

If yes please list.______________________________

If yes, please explain and provide a physicians' note ______________________________

____

____

Is your child currently taking any medications?

If yes, please explain ______________________________

Has your child ever had trouble walking, climbing, reaching, holding on to things? ________ Yes ________ No

Does your child get frequent ear infections? _________ Yes ______ No

Has you child ever had trouble hearing? ________ Yes ______ No

Has your child ever had trouble seeing? ________ Yes ______ No

Have you ever suspected that your child have any vision problems?

________ Yes ______ No

CHILD'S DEVELOPMENT

Is your child potty trained? ________Day _________Night

Does your child require help? ________ Yes ______ No

Need to be reminded? ________ Yes ______ No

Other comments______________________________

How does your child react to new foods? ______________________________

Is your child willing to try new foods? ______________________________

Do you have any concerns about sleeping habits? ______ Yes _____ No

CHILD'S DEVELOPMENT CON"T

Can your child:

Feed him or herself using utensils? ________ Yes ______ No

Wash and dry their own hands? ________ Yes ______ No

Dress with little or no assistance? ________ Yes ______ No

Speak so that they can be understood? ________ Yes ______ No

Express their thoughts and needs easily? ________ Yes ______ No

Is your child:

Affectionate ________ Yes ______ No

Shy/ Quiet ________ Yes ______ No

Talkative ________ Yes ______ No

Emotional ________ Yes ______ No

Stubborn ________ Yes ______ No

Highly Active ________ Yes ______ No

Does your child:

make friends easily? ________ Yes ______ No

have tantrums? ________ Yes ______ No

use crayons/ markers to scribble or draw?

listen to stories being read? ________ Yes ______ No

turn pages of a book and look at pictures? ________ Yes ______ No

recall stories or events? ________ Yes ______ No

enjoy playing alone or with imaginary friends? ________ Yes ______ No

talk with friends? ________ Yes ______ No

follow age appropriate directions? ________ Yes ______ No

have fears of:
- strangers ________ Yes ______ No
- storms ________ Yes ______ No
- dark ________ Yes ______ No
- animal ________ Yes ______ No
- other________________________________

How do you handle the fears?________________________________

What are your child's favorite activities? ________________________________

____

Does your child have opportunities to play with other children? ____________

____

Who are your child's playmates? ________________________________

____

Are there other things you would like to share about your child? ____________

____

____

REFERRAL INFORMATION

If you would like referral information for community resources for your family, please indicate below.

Social Services_____ Food Pantry______ Head Start_____

Birth To Three_____ Health Department_____ Counseling Services_____

Is your child currently enrolled in:

_____Head Start _____Speech _____Other Please specify__________________

____

____

Does your child have an IEP from a referral agency? _____yes _____no

If yes please indicate which agency and or district____________________________

____

____