Dear Parents:

Please take a few moments to introduce your child to us through this questionnaire.

This form has four parts that ask for information about your child:

Part 1:	Personal background information about your child.
Part 2:	Health information about your child.
Part 3:	Self-Help Development about your child's ability to care for him/herself.
Part 4:	Social Development about how your child behaves with other people.

Please read through the form and respond to all items as carefully as you can. You are an important source of information about your child. The information and answers that you provide enable us to better understand the whole child. Information shared on this questionnaire will remain confidential and will only be shared with your child's classroom teacher and specialist teachers. We greatly appreciate your time in completing this form and look forward to working with you and your child.

Child's Name (First, Last):_____

Name child will be using in school:_____

Date of Birth: ____/____/____ Gender: ____Male ____Female

Person completing this survey: ___Mother ___Father ___Guardian ___Caregiver ___Other (specify) _____

Part 1: Personal Information

Living Situation

1. Who does your child live with? (Check all that apply)

___Mother ___Father ___Stepmother ___Stepfather ___Mother's Partner ___Father's Partner
___Grandmother ___Grandfather ____Other relative (specify) _____
___Foster family: Case worker's name and phone #:_____
___Other (specify)_____

2. Is the child adopted? ___Yes ___No
3. If your child is adopted at what age did he/she join the family? _____

Siblings

4. Does your child have brothers or sisters? ___Yes (Please list below) ___No

Name of brother/sister	Age	Name of School Attending	Does this child live at home with your student?

5. My child's birth order in the family is ___ out of ___children.

Language

6. Language first spoken by your child:_____
7. Language child uses most often:_____
8. Language parents use most often:_____
9. Does your child understand and speak English? ___ Yes ___Limited/Partially __Not at all

School situation

10. What are your concerns about your child's schooling? _____
    _____
11. Has your child attended a preschool/ daycare? ___Yes ___No If yes, for how long? (years/months)_____
12. How many hours per week has your child most recently attended preschool or daycare?_____
13. What is the name and location of your child's preschool/daycare?_____
    Preschool or Daycare contact person's name:_____

Home Situation

Events at home often influence a child's behavior, for example: changes in the family, such as a new sibling, separation or divorce, moving into a new home, loss of a family member, etc. Knowing about these transitional times will allow us to provide special attention, understanding, and care that your child needs.

14. Has anything happened recently in your child's life that might have an effect on him/her? __Yes __No
    If so, please explain.

_____

_____

15. Is there anything else you would like to share about your child that you feel would help us create a positive environment and relationship for your child?

_____

_____

_____

Part 2: Health Information

Medical/Health Information

16. Did your child receive early interventions? ___Yes ___No
    If YES, with whom?_____
17. Has your child seen an optometrist or ophthalmologist? ___Yes ___No
18. Does your child wear glasses? ___Yes ___No
19. Do you suspect your child has a vision problem? ___Yes ___No
    Comments:_____
20. Do you suspect your child has a hearing problem? ___Yes ___No
    Comments: _____
21. Has your child had frequent ear infections? ___Yes ___No
22. Has your child had ear tubes inserted? ___Yes ___No
    If YES, at what age(s)? _____
23. Does your child speak loudly? ___Yes ___No
24. Does your child take prescription medications on a routine, daily basis? ___Yes ___No
    If YES, please list:_____
25. Has your child ever had a special assessment for : (Please circle, if applicable)
    Cognitive or Developmental exam **Psychological exam** **Neurological exam**
    If your child has had one of the above exams, please describe the reason(s):_____
    _____
    Name and location of person(s) who administered the exam:_____
    _____

Speech/Language Information

26. My child has had a **speech and language evaluation**. ___Yes ___No
27. If YES, did he/she receive therapy? ___Yes ___No For how long?_____
28. My child currently receives **speech and language therapy.** ___Yes ___No
    Therapist's name/agency:_____
29. My child is generally understood by people outside the family. ___Yes ___No
30. I find myself restating what my child has said to others. ___Yes ___No

Motor Information

31. My child can **independently:** (check all that apply)
    ___ Throw or catch a ball ___ Go upstairs with alternating feet ___ Go down stairs with alternative feet
    ___ Hop on one foot ___ Hop on two feet ___ Balance on one foot for 3-5 seconds
32. My child has had a **physical therapy evaluation**. ___Yes ___No
    If YES, did he/she receive therapy? ___Yes ___No For how long?_____
33. My child currently receives **physical therapy.** ___Yes ___No
    Therapist's name/agency:_____

Sensory Information

34. My child is fearful of loud noises. ___Yes ___No
35. My child does not like crowds. ___Yes ___No
36. My child is a picky eater (does not like certain food textures, colors, etc.) ___Yes ___No
37. My child becomes overwhelmed in new situations. ___Yes ___No
38. Certain clothing (tags, different materials, etc.) bother my child. ___Yes ___No

Fine Motor Information

39. My child can hold a crayon and draw/color with it. ___Yes ___No
40. My child can string beads. ___Yes ___No
41. My child can snip with scissors. ___Yes ___No
42. My child can copy a horizontal line, a vertical line and a circular shape. ___Yes ___No
43. My child has had an **occupational therapy and/or sensory evaluation.** ___Yes ___No
    If YES, did he/she receive therapy? ___Yes ___No For how long?_____
44. My child currently receives **occupational therapy.** ___Yes ___No
    Therapist's name/agency:_____

Attention Information

45. My child gives eye contact to the person speaking. ___Yes ___No
46. My child sticks to one activity for at least 5 minutes at a time (not including computer or TV) ___Yes ___No
47. My child perseverates or excessively over-focuses on things or ideas. ___Yes ___No
48. My child has been diagnosed with **ADD** or **ADHD.** ___Yes ___No

Part 3: Self-Help Information

49. My child can **independently**: (check all that apply)

___Put away toys	___Hang up coat	___Completely get dressed
___Clean up a spill	___Follow a 2-step direction	___Take care of all toileting needs
___Put shoes on correct feet	___Blow or wipe nose without being asked	___Ask an adult for help, when needed
___Wash hands	___Brush teeth	___Drink from an open cup (not sippy)

Part 4: Social Development Information

50. My child initiates play with other children. ___Yes ___No
51. My child has opportunities to play with other children his/her own age. ___Yes ___No

52. My child easily separates from parents. ___Yes ___No
53. My child is able to take turns. ___Yes ___No
54. My child gets along well with other children. ___Yes ___No
55. My child is fearful/anxious and worries a lot. ___Yes ___No
56. Does your child exhibit any serious behavior problems? (Check those that apply).

___Defiance of adults/non-compliant ___Excessive, long-lasting tantrums ___Biting

___Aggressive/violent behavior towards others ___Other:_____

57. What is your child's reaction to stress? (Check all that apply)

___Cries ___Headache ___Stomachache ___Bites ___Other:_____

Discipline

58. Are there challenges with behavior management at home? ___Yes ___No

What is the most effective in establishing acceptable behavior:_____

_____

59. My child's **strengths** are: _____

_____

_____

60. There is additional information that I would like to share. ___Yes ___No

_____

_____

_____

_____