WESTON WINDOWS PRESCHOOL
Parent/Guardian Questionnaire

Dear Parents: Please fill out this questionnaire, these questions are designed to help us to get to know your child. This information, along with our observations, will help us plan the best start in school for your child.

PERSONAL INFORMATION

Child's Name: _____
(First, Middle, Last)
Date of Birth: ___/___/_____ Nickname/Prefers to be called: _____

Parent Name #1	
Home Address	
Parent Name #2	
Home Address (if different)	
Main Phone	
Home Phone	
Work Phone	
Parent #1 Email	
Parent #2 Email	
Language Spoken at Home	
Country of Citizenship	
City/Town of Birth	

HOUSEHOLD MEMBERS (please include parents)

Name	Age	Occupation/Grade	Relationship to Child

GENERAL HEALTH

PREGNANCY: Normal, without complications?

Complications? Please explain:

_____

_____

_____

Is he/she adopted? Yes____ No ____

LABOR

Spontaneous: ___ Induced: ___ Hours in Labor: ___ Vaginal: ___ Full Term: ___

Full Term: ___ How Many Weeks: ___ Premature: ___ How Many Weeks: ___

Multiples: ___ # of Multiples: ___ Cesarean (Planned): ___ Cesarean (Emergency): ___

Complications During Delivery? If so, please explain:

_____

_____

_____

BIRTH WEIGHT: ___ lbs ___ oz

Did your child experience any difficulties in the hospital or after? (i.e., placed in neonatal unit, jaundice, cyanosis, trouble breathing, difficulty sucking/feeding, infection, tachycardia or bradycardia?) If so, please explain:

_____

_____

_____

MEDICAL DATA

Pediatrician	
Phone/Address	
Specialist	
Phone/Address	
Dentist	
Phone/Address	

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING:

	YES	NO	EXPLAIN
Asthma			
Indigestion			
Convulsions			
Constipation			
Diarrhea			
Vomiting			
Frequent Fevers			
Sinus Trouble			
Nose Bleeds			
Bed Wetting			
Headaches			
Nightmares			
Thumb Sucking			
Nail Biting			
Difficulty Sleeping/Tired			
Heart Trouble			
Difficulty Hearing			

Difficulty Seeing	YES	NO	
Other:			

ALLERGIES

	YES	NO	EXPLAIN
Food Allergies?			
Allergies to Medications?			
Allergies to Insect Stings?			
Allergy Life Threatening? Requiring Epi Pen?			
Other Allergies?			

EYES

YOUR CHILD HAS/HAD:	YES	NO	EXPLAIN
Crossing or Turning Eyes?			
Squinting?			
Corrective Lenses/Glasses?			
Eye Surgery?			
Eye Infections?			
Tendency to Sit Close to Tv?			
Wears/Wore Eye Patch?			
Had Vision Checked?			
Other Eye Complaints?			

EARS

YOUR CHILD HAS/HAD:	YES	NO	EXPLAIN
Ear Infections/Fluid?			
Difficulty Hearing?			
Asks for Louder TV?			
Difficulty Hearing Words Correctly?			
Responds When Called?			
Hearing Aid?			
Frequent Need for Directions?			
Favors One Ear?			

YOUR CHILD HAS/HAD:	YES	NO	EXPLAIN
Hearing Test?			

If Yes, When?	
By Whom?	

RESULTS OF HEARING TEST

	YES	NO	EXPLAIN
Been Seen my an ENT?			
Ear Surgery? Tubes?			
Problems with Colds?			

ACCIDENTS

HAS YOUR CHILD EVER?	YES	NO	EXPLAIN
Been in a Serious Accident?			
Experienced Severe Trauma?			
Experienced Head Injuries?			
Been Hospitalized?			
Other			

Has your child ever experienced significant life changes, trauma, or psychological stressors? (ie. divorce, relocation, death of close family member…. Please explain:

_____

_____

_____

DEVELOPMENTAL HISTORY

Does anyone in the family have a history of developmental or learning problems? Please specify:

_____

_____

_____

Did your child receive Early Intervention Services? Please specify: No: ___ Yes: ___

_____

_____

_____

Has your child had any evaluations? Please specify:

By Whom?	
When?	
Type of Evaluation?	

Findings or recommendations?

_____

_____

_____

DEVELOPMENTAL MILESTONES

At what age did your child:

	Age
Begin Babbling	
Use Single Words	
Combine Words	
Speak Simple Sentences	
Understand Simple Commands	
Sit Aloe	
Crawl	
Stand without Support	
Walk	
Climb Stairs	
Run	
Become Toilet Trained	

SPEECH AND LANGUAGE

Are you concerned about your child?	YES	NO	EXPLAIN
Making particular sounds?			
Way his/her voice sounds?			
Repeating words or sounds?			
Difficulty with pronouncing certain words or names?			

LANGUAGE

	YES	NO
Does your child seem to understand you?		
What is your child's average sentence length?		
Do you have concerns about your child's memory?		
Do you have concerns about your child's vocabulary?		
Is there a family history of speech problems?		
Does your child stutter?		
Can your child retell a simple story?		

If applicable, is your child aware he/she has difficulties with speech/language? If so please explain:

_____

_____

_____

COMMUNICATION

	YES	NO
Does your child talk about his/her experiences (what he/she did during the day) in detail?		
Does your child ask questions that begin with “what, who, when, where and why?”		
Does your child say his/her own first and last names when asked?		
Does your child repeat short songs, poems or nursery rhymes?		

If your child is not yet talking, how does he/she communicate? Mark all that apply:

Crying: ___ Grabbing at Objects: ___ Facial Expressions: ___ Pointing: ___

Hand Gestures: ___ Pulls You Toward Object: ___ Uses “Own Language”: ___

Other: _____

ARTICULATION SCREEN

Can your child correctly produce these developmental sounds? Mark all that apply:

My: ___ Home: ___ Pie: ___ Hop: ___ Won: ___ To: ___ Hat: ___ Bee: ___ Tub: ___

High: ___

HOME ENVIRONMENT

What does your child like to do best at home?	
Does he/she have a favorite activity?	
Can he/she occupy him/herself while you are out of sight?	
Can your child shift activities comfortably?	
Does your child get bored easily with any one activity?	
Does your child prefer to play alone or with others?	
How old are your child’s playmates?	
How long can your child play alone?	

How long can your child play with a friend?	
How long can your child play with a sibling?	
How long can your child play with you?	
Does your child like to have stories read to him/her?	
How long can he/she pay attention to stories?	
What kind of stories does he/she like?	
What TV show(s) does your child watch?	
How many hours of TV a day?	
How many hours does your child sleep?	
Does your child nap regularly, if so how long?	
Does your child sleep restlessly or soundly?	
Does your child drink from a cup or glass with little spilling?	
Can your child take care of all toileting needs including flushing the toilet and washing hands?	
Does your child put away toys and clothes in their proper place when asked?	
Does your child like to play with puzzles?	
Which hand does your child use for feeding or drawing?	
What types of pretend play does your child enjoy?	

OCCUPATIONAL/PHYSICAL THERAPY CHECKLIST

FINE MOTOR/PERCEPTION:
Please mark the following items that your child can complete:

Joins large pop beads at right ends: ___
Identifies which objects are larger or smaller: ___
Builds tower of 6 blocks: ___
Builds 3 block bridge: ___
Points to eight body parts on command: ___
Copies isolated strokes in different directions: ___
Copies a cross with demonstration: ___
Colors within an area: ___
Turns book pages easily: ___
Matches primary colors: ___
Builds tower of 10 blocks: ___
Points to four body parts on command: ___
Draws a person with three parts: ___
Copies a circle: ___
Copies a square: ___
Attempts to cut a straight line (if already introduced to scissors): ___

GROSS MOTOR
Please mark the following items that your child can complete:

Rides ride on toy: ___
Hops on one foot: ___
Catches a ball: ___
Climb on a jungle gym: ___
Rides a tricycle: ___
Throws a ball: ___
Kicks a ball: ___
Climbs off jungle gym: ___

SELF HELP
Please mark the following items that your child can complete:
Uses a spoon and fork: ___
Pulls down garments with elastic waist: ___
Puts on pants: ___
Dress her/himself: ___
Removes shoes: ___
Pull on T-Shirt: ___
Puts on socks and shoes: ___
Select clothes: ___

PRESCHOOL/GROUP EXPERIENCES
Is your child currently in daycare or preschool setting? If so, please explain:

Program Name	
Days/Times	
Child Reaction	
Teacher Feedback	

BEHAVIOR
Does your child consistently:

	YES	NO	EXPLAIN
Cry or whine?			
Seems to be quiet?			
Pay attention to you?			
Make up little games?			
Seems to be restless?			
Say “I can’t” before trying?			
Have temper tantrums?			
Seems to be a leader?			
Cry when he/she does not get her/his own way?			
Move slowly?			
Play well with other children?			
Get upset easily?			
Seems to have friends?			
Enjoy being held?			
Comfortable using play dough, sand and finger-paint?			

Engage in repetitive behaviors/movements of an object (flappling, spinning, opening and shutting doors)?			
Overactive?			
Have a short attention span?			
Have mood swings?			
Bangs head?			
Hurts him/herself?			
Overly afraid?			
Runs into things?			

Does your child display any special talents, such as music, art, performing for other, leading other children or engaging in physical activities?

_____

_____

_____

Do you have any special concerns about your child? Please explain:

_____

_____

_____

Is there anything else you would like us to know about your child?

_____

_____

_____

Print Name: _____

Signature: _____

Today's Date: _____

Relationship to Child: _____

Thank you for taking the time to complete this form.