For Office Use Only **Child's Name:**_____**Screening Date:**_____**Arrival Time:**_____

"Where All Children Come First"

Francis T. Bresnahan School
Parent Questionnaire
For Preschool Screening

NEWBURYPORT PUBLIC SCHOOLS

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

Parent 1/Guardian 1	Parent 2/ Guardian 2
Mr/Mrs/Ms/Other:_____	Mr/Mrs/Ms/Other:_____
Name (First/Last)_____	Name (First/Last)_____
Address:_____	Address:_____
City:_____State:____Zip:_____	City:_____State:____Zip:_____
Relationship to Child:_____	Relationship to Child:_____
Home Phone:_____	Home Phone:_____
Work Phone:_____	Work Phone:_____
Cell Phone:_____	Cell Phone:_____
Email for school contact:_____	Email for school contact:_____
Has custody of child? ____Yes ____ No ____Joint	Has custody of child? ____Yes ____ No ____Joint
Does child live with this parent? ___Yes ___No	Does child live with this parent? ___Yes ___No

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 preschooler?

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:_____
14. May we have permission to contact the previous teacher/daycare provider? ___Yes___No *If yes, please sign below.*
    Signature:_____Date:_____

Home Situation

15. When was the last time you moved?_____
16. How often have you moved in the last 5 years?_____
17. Have any of the following occurred?
    Parents separated or divorced ___Yes ___No When?_____
    A death or major loss ___Yes ___No Who/When_____
    Other major events that may have upset your child?_____
    _____Date:_____
18. Has your child reacted to any of the above situations with behaviors that concern you? _____
    _____
    _____
19. Are there any family beliefs, traditions (religious or otherwise) that you would like the school to be aware of? _____
    _____

Part 2: Health Information

Birth Information

20. Was the child a full term baby? ___Yes ___No
21. Were there any complications with the pregnancy or at birth? ___Yes ___No
    If YES explain:_____

Medical/Health Information

22. Did your child receive Early Intervention Services? ___Yes ___No
    If YES, with whom?_____

23. Has your child seen an optometrist or ophthalmologist? ___Yes ___No
24. Does your child wear glasses? ___Yes ___No
25. Do you suspect your child has a vision problem? ___Yes ___No
    Comments:_____
26. Do you suspect your child has a hearing problem? ___Yes ___No
    Comments:_____
27. Is your child under the care of an audiologist or ear, nose and throat (ENT) specialist? ___Yes ___No
28. Has your child had frequent ear infections? ___Yes ___No
29. Has your child had ear tubes inserted? ___Yes ___No
    If YES, at what age(s)?_____
30. Does your child speak loudly? ___Yes ___No
31. Does your child have a significant medical history due to an accident, illness or medical condition? ___Yes ___No
    If YES, please describe:_____
32. Has your child ever been hospitalized? ___Yes ___No
    If YES, please explain:_____
33. Does your child take prescription medications on a routine, daily basis? ___Yes ___No
    If YES, please list:_____
34. Does your child have any allergies? ___Yes ___No
    If YES, please list:_____
35. Does your child have an EPI PEN? ___Yes ___No
36. Does your child use an asthma inhaler? ___Yes ___No
37. 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:_____
    _____
38. Has your child ever experienced a major psychological trauma? ___Yes ___No
    If YES, please describe:_____
39. May we have permission to contact your child's medical provider, as needed?___Yes ___No *If yes, please sign below*
    Medical provider's name: _____ Phone #:_____
    Signature:_____ Date:_____

Speech/Language Information

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

Motor Information

44. My child can **<u>independently:</u>** (check all that apply)
    ___ Throw or catch a ball ___ Go up stairs 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
45. My child has had a **physical therapy evaluation**. ___Yes ___No
    If YES, did he/she receive therapy?___Yes ___No For how long?_____
46. My child <u>currently</u> receives **physical therapy.** ___Yes ___No
    Therapist's name/agency:_____

Sensory Information

47. My child is fearful of loud noises. ___Yes ___No
48. My child does not like crowds. ___Yes ___No

Child's Name:_____

49. My child is a picky eater (does not like certain food textures, colors, etc.) ___Yes ___No
50. My child becomes overwhelmed in new situations. ___Yes ___No
51. Certain clothing (tags, different materials, etc.) bother my child. ___Yes ___No

Fine Motor Information

52. My child can hold a crayon and draw/color with it. ___Yes ___No
53. My child can string beads. ___Yes ___No
54. My child can snip with scissors. ___Yes ___No
55. My child can copy a horizontal line, a vertical line and a circular shape. ___Yes ___No
56. 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?_____
57. My child currently receives **occupational therapy.** ___Yes ___No
    Therapist's name/agency:_____

Attention Information

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

Part 3: Self-Help Information

62. 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)

63. Is your child toilet-trained? ___Yes ___No *If yes, for how long?*_____

Part 4: Social Development Information

64. My child initiates play with other children. ___Yes ___No
65. My child has opportunities to play with other children his/her own age. ___Yes ___No
66. My child easily separates from parents. ___Yes ___No
67. My child is able to take turns. ___Yes ___No
68. My child gets along well with other children. ___Yes ___No
69. My child is fearful/anxious and worries a lot. ___Yes ___No
70. 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:_____

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

___Cries ___Headache ___Stomachache ___Bites ___Other:_____

Discipline

72. Are there challenges with behavior management at home? ___Yes ___No
    If yes, what is the most effective in establishing acceptable behavior:_____
    _____
    _____
73. My child's **strengths** are:_____
    _____
    _____
74. There is additional information that I would like to share. ___Yes ___No
    _____
    _____
    _____
    _____

Child's Name:_____