KSD #131
Parent Questionnaire

Child's Name_____ Boy____ Girl____ Birthdate_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Work Phone: _____
Cell Phone_____ Email Address_____
Father's Name_____ Age____ Occupation_____ Education_____
Mother's Name_____ Age____ Occupation_____ Education_____
Siblings:
Name_____ Age_____ grade_____ School_____
Name_____ Age_____ grade_____ School_____
Name_____ Age_____ grade_____ School_____
Name_____ Age_____ grade_____ School_____
Child lives with: _____

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Date of last doctor exam _____ Current height_____ weight _____
List any medications that this child takes regularly and why it is needed_____
_____
Were there any complications with the pregnancy of this child? Yes_____ No _____
If yes, please describe_____
Has this child ever required any special medical care or hospitalizations? Yes_____ No _____
If yes, please explain_____
Has this child ever had a serious accident or injury? Yes_____ No _____ If yes, please explain_____
Do you have any concerns with this child's hearing? Yes_____ No _____ If yes, please describe_____
Do you have any concerns with this child's vision? Yes_____ No _____ If yes, please describe_____
At what age did this child begin toilet training? _____ Has training completed? _____
Has this child been diagnosed with or experienced any of the following?

____ Asthma	____ Frequent Fevers	____ Headaches	____ Fatigue
____ Digestive problem	____ Sinus problem	____ Ear infection	____ Nose bleeds
____ Allergies	____Thumb sucking	____ Anxiety	____ Hyperactivity
____ hearing problems	____ Vision problems	____ Bedwetting	____ Seizures
____ Heart problems	____ Poor appetite	____ Nightmares	

____Other _____

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At what age did this child say his/her first words? _____ Put 2 and 3 words together? _____ Say sentences? _____
Are there any concerns about this child's speech and language abilities? Yes_____ No _____
If yes, please explain_____
Other than English, are there other language(s) spoken/understood in your home?
Yes_____ No _____ If Yes, What language(s)? _____

Does this child: (circle one)

Sing little songs or commercials?	Yes	No	Not Sure
Cry or Whine?	Yes	No	Not Sure
Seem to be unusually quiet?	Yes	No	Not Sure
Repeat actions or words needlessly?	Yes	No	Not Sure
Pay attention to what you say or do?	Yes	No	Not Sure
Seem to be restless or fidgety?	Yes	No	Not Sure
Seem to be happy?	Yes	No	Not Sure
Say "I can't" without trying?	Yes	No	Not Sure
Have temper tantrums?	Yes	No	Not Sure
Seem to be a leader?	Yes	No	Not Sure
Cry when not given his or her way?	Yes	No	Not Sure
Move slowly?	Yes	No	Not Sure
Act without reason, on the spur of the moment?	Yes	No	Not Sure
Play well with other children?	Yes	No	Not Sure
Get upset easily?	Yes	No	Not Sure
"Rock" his or her body?	Yes	No	Not Sure
Have many unusual or different ideas?	Yes	No	Not Sure

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What are this child's favorite activities at home? _____
What are this child's favorite toys? _____
Does this child prefer to play alone or with others? _____
How does this child get along with siblings and playmates? _____
Do you have any concerns about this child? (fears, behaviors, etc.?) _____
_____
Does this child attend preschool? _____ Yes _____No
If yes, where? _____ How long has he/she attended? _____
If no, are there financial circumstances that make it difficult? ___Yes ____No List any other reasons why this child does not attend preschool _____
Does anyone read stories to this child? ____ Yes ____No if yes, who?_____
What kind of stories does he/she like?_____
How many hours each day does this child watch TV? _____ What does he/she watch?_____
_____
Does this child know his/her: Numbers? _____ ABC's? _____ Colors? _____
Does this child seem to have difficulty learning numbers, ABC's or colors? _____
Please write any other information that would help us get to know/ understand your child below:
_____
_____
_____
_____

Form completed by: _____ date_____ relationship to child_____
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