PRESCHOOL PARENT QUESTIONNAIRE

Your responses on this questionnaire will help us to learn more about your child. Please complete each item and return to the director or your child's teacher. There are no "right" or "wrong" answers to the questions. Please add longer responses to a separate piece of paper if needed.

Child's Name: _____

Date of Birth: _____

What languages are spoken in the home?

_____

PLEASE TELL US ABOUT YOUR CHILD:

1 Describe a typical weekday for your child:

_____
_____
_____
_____
_____
_____
_____
_____

2 Describe a typical weekend for your child:

_____
_____
_____
_____
_____
_____
_____
_____

3 What are two things that your child likes to do best?_____

_____
_____

4 What are two things your child does not like to do?_____
_____
_____

5 What is your favorite thing to do with your child?_____
_____
_____

6 What are three words you feel best describe your child?_____
_____
_____

7 What do you enjoy most about your child? What makes them special?_____
_____

TELL US ABOUT YOUR CHILD'S DAY:

1 What is your child's normal nap time? _____ bedtime? _____
How long does your child normally sleep? _____ Where does your child usually fall asleep? (e.g. in their bed, in your bed, in your arms, on the sofa, etc.)
_____
_____

2 What time does your child normally wake up in the morning?
_____

3 How does your child respond to accidents? (e.g. something breaking, an unexpected event, etc.)
_____
_____

4 What does your child normally eat for breakfast?_____
_____

5 What does your child like to eat most?_____
_____

6 Are there any foods that your child will not eat?_____
_____

7 Does your child feed themselves using a spoon and/or fork?_____
_____

8 Does your child dress themselves?
_____
_____

9 What are your child's responsibilities at home? (e.g. putting things away, setting the table, etc.)
_____
_____

10 Does your child use the toilet independently? If not, please tell us where they are in this process.
_____
_____

11 Please tell us about your approach to discipline? (e.g. time-outs, spanking, redirecting, etc.)
_____
_____
_____
_____
_____

MEDICAL HISTORY:

1 Were there any significant problems during pregnancy or directly following birth that might have an effect on your child's development (e.g. Premature birth, low birth weight, etc.)?_____
_____

2 Have you ever suspected that your child has vision problems? Yes No
If yes, please explain:

_____

_____

3 Have you ever suspected that your child has hearing problems? Yes No
If yes, please explain:

_____

_____

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

If yes, please explain:

_____

_____

5 Does your child have food allergies? Yes No
If yes, please describe:

_____

_____

6 Is your child presently on any medications? Yes No
If yes, please describe:

_____

_____

DOES YOUR CHILD:

Have older or younger siblings?

_____

Speak so that they can be understood by others? Yes No

_____

Express their thoughts and needs easily? Yes No

_____

Use crayons and/or markers to scribble or draw? Yes No

_____

Listen to stories being read? Yes No

_____

Recall and retell stories or events? Yes No

Have media time? How much and what type?

Talk with your friends/relatives who come to visit? Yes No

Follow simple, age-appropriate directions? Yes No

Have opportunity to play with other children? Yes No

Is there any other information regarding your child's development that you would like to share with us?