



"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 currently 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 **independently**: (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 currently 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
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

