

2017 / 2018

### PARENT QUESTIONNAIRE

*Your responses on this questionnaire will help us to learn more about your child. Please complete each item and return it with your completed application form. There are no "right" or "wrong" answers to the questions. Please add longer responses to a separate piece of paper.*

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 him/her special?

\_\_\_\_\_

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

\_\_\_\_\_  
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Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**TELL US ABOUT YOUR CHILD'S DAY.**

1. What is your child's normal naptime? \_\_\_\_\_ bedtime? \_\_\_\_\_

How long does he/she normally sleep? \_\_\_\_\_

Where does he/she usually fall asleep? (in his/her bed, in your bed, in your arms, on the sofa...)

\_\_\_\_\_

2. What time does your child normally wake up in the morning? \_\_\_\_\_

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

\_\_\_\_\_

4. What does your child normally eat for breakfast?

\_\_\_\_\_

5. What does your child like to eat most?

\_\_\_\_\_

6. Are there any foods that he/she will not eat?

\_\_\_\_\_

7. Does your child feed him/herself using a spoon and/or fork?

\_\_\_\_\_

8. Does your child dress him/herself?

\_\_\_\_\_

9. What are your child's responsibilities at home? (putting things away, set table etc.)

\_\_\_\_\_

10. Does your child use the toilet independently? If not, please tell us where she/he is in this process.

\_\_\_\_\_

11. Please tell us about your approach to discipline? (time-out, spanking, redirecting...)

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY**

1. Were there any significant problems during pregnancy or directly following birth that might have an effect on your child's development (ie. 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 he or she can be understood by others?  Yes  No \_\_\_\_\_

Express his or her 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 \_\_\_\_\_