**2020 / 2021**

## PRESCHOOL PARENT QUESTIONNAIRE

Puddletown School

*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 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?

Signature of Parent/Guardian: _____ Date: _____