Hayward Unified School District

Dr. Matt Wayne, ***Superintendent***

Preschool Questionnaire

Special Education Department

(510) 784-2600 ex 72611

Please complete the Parent Questionnaire

After completing the Questionnaire, please bring the packet to the following office:

Parent Resource Center Room 15

24823 Soto Road, Hayward, CA 94544

Questions contact: Elizabeth Del Muro

Phone # (510) 784-2600 ex 72611

Email: ed685@ husd.k12.ca.us

HAYWARD UNIFIED SCHOOL DISTRICT
EARLY INTERVENTION SERVICES

PARENT QUESTIONNAIRE

Please Print legibly

I. IDENTIFYING INFORMATION Today's date: _____

Child's Name: _____ Birth date: _____ Age: _____ Sex :_____

Address: _____ Home School: _____

Child Lives with_____

Home Phone _____ Cell/Work Phone _____ email_____

Language(s) spoken at home _____ Language(s) Child Speaks at Home_____

Other languages child of which the child is regularly exposed: _____

II. CONCERNS

What are your main concerns about your child? (Please describe in detail)_____

_____

How old was your child when you first became concerned? _____

Has your child been diagnosed with any conditions effecting development? _____

_____

What strategies have you used to assist your child? _____

_____

_____

Please describe your child's daily routine.(Give examples)_____

_____

_____

What TV programs does he/.she watch?_____

What is your families' mealtime routine?_____

What is your child's bedtime routine? _____

Do you take your child to stimulating places such as:

	How often	How does your child respond?
Library		
Museums		
Other Special activities		

_____

Do you have books at home or access to children's books? If so, how often do your read with your child? _____

_____

How much time do you spend with your child having conversations? Please describe_____

_____

_____

How do you play with your child? _____

_____

_____

III. FAMILY HISTORY

Mother's Name _____Age_____ Education level_____

Any learning, developmental or health problems? Please describe_____

_____

Father's Name _____Age_____ Education Level _____

Any learning, developmental or health problems? Please describe_____

_____

Names of Siblings	Age	School Attending/ problems?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are both parents living in the home? _____ Who else living in the home? _____

_____

Is there a family history of:

	YES	NO	Relationship to child
Speech delays	◯	◯	_____
Developmental delays	◯	◯	_____
Autism	◯	◯	_____
Mental health problems	◯	◯	_____
Learning disabilities	◯	◯	_____
Depression	◯	◯	_____
Rheumatoid arthritis	◯	◯	_____
Diabetes Type I	◯	◯	_____
Diabetes Type II	◯	◯	_____
Asthma	◯	◯	_____
Epilepsy/Seizures	◯	◯	_____
Hearing Loss	◯	◯	_____
Vision Impairments	◯	◯	_____
Other	◯	◯	_____

Have there been any home/family experiences or changes that may have had an impact on your child (divorce, death, frequent residence changes, prolonged illnesses)?_____

_____

Are there any other factors that may have had an impact on your child's development and well-being? _____

_____

III. PRE-NATAL HISTORY

	NO	YES	DESCRIBE
Illness during pregnancy	◯	◯	_____
Accidents during pregnancy	◯	◯	_____
Excessive weight gain	◯	◯	_____
High blood pressure	◯	◯	_____
Edema	◯	◯	_____
Bleeding or spotting	◯	◯	_____
Infections	◯	◯	_____
Exposure to toxins, x-ray	◯	◯	_____
Cigarettes, alcohol, drugs	◯	◯	_____
Rh factor	◯	◯	_____
Other complications	◯	◯	_____
Medications	◯	◯	_____

IV. NEWBORN INFORMATION

Full-term _____Premature _____Overdue_____ Length of pregnancy _____Prenatal Care Began_____

Vaginal delivery _____ Caesarean section _____ Breech _____ Other _____

Birth weight _____ Length _____ Apgar, if known _____ _____

Condition: Good _____Jaundice_____ Respiratory problems_____ Feeding Problems_____Other_____

Oxygen, intubation, bilirubin lights, surgery or extended hospitalization required? No ◯ Yes ◯ If yes, please explain:

_____

_____

Any difficulties with feeding or sleeping in newborn period? No ◯ Yes ◯ If yes, please explain _____

_____

V. DEVELOPMENTAL MILESTONES

	Approx. Age		Approx. Age
Sat without support	_____	Drank from a cup	_____
Crawled on hands and knees	_____	Weaned from bottle	_____
Walked without needing support	_____	Fed self with spoon	_____
Spoke first real words (other than "mama", "papa")	_____	Pedaled tricycle	_____
Combined 2-3 words	_____	Toilet trained	_____

Regression or Loss of skills? Please describe_____

VI. HEALTH HISTORY

Does child have a history of:

	NO	YES	DESCRIBE	TREATMENT
frequent colds	☐	☐		
ear infections	☐	☐		
hearing problems	☐	☐		
vision problems	☐	☐		
high fever	☐	☐		
seizures	☐	☐		
surgeries	☐	☐		
serious illnesses	☐	☐		
serious injuries	☐	☐		
allergies	☐	☐		
asthma	☐	☐		
eczema	☐	☐		
Loss of Consciousness	☐	☐		
Head trauma	☐	☐		
Cerebral Palsy	☐	☐		
Heart Problems	☐	☐		
Special Syndrome	☐	☐		
Take any medication	☐	☐		

Special Tests:

	NO	IF YES, DATE	By WHOM	RESULTS
Vision	☐	☐		
Hearing	☐	☐		
Other	☐	☐		

Name of child's pediatrician: _____ Medical group_____
Kaiser #_____ Date of last physical exam_____
List other health providers_____
What have you been told about your child's development by physicians, specialists, other agencies, or preschool teachers?

_____

VII. SPECIAL SERVICES/AGENCY INVOLVEMENT

Has your child received any special type of evaluation or therapy services by specialists such as speech and language, psychotherapy, genetic evaluation? (none of the individuals or agencies will be contacted without parent/guardian permission)

NAME & PROFESSION	TYPE OF SERVICE	ADDRESS	PHONE /Email

List any other agencies that have been involved with your family or child (e.g. RCEB, CHO, CPS, CCS)

AGENCY	CONTACT PERSON	ADDRESS	PHONE/email

VIII. PRESCHOOL EXPERIENCE

Has your child had any previous daycare or preschool experience? Yes ☐ No ☐

DATES BEGAN & ENDED	PRESCHOOL/DAYCARE NAME	CHILD"S REACTION

IX. SOCIAL-EMOTIONAL DEVELOPMENT

What are your child's strengths? _____

_____

Describe the general disposition of your child: (Please circle all that apply:)

☐ Happy ☐ moody ☐ active ☐ alert ☐ irritable ☐ strong ☐ Demanding
☐ Difficult to clam/soothe ☐ Easy to care for ☐ shy ☐ anxious ☐ Friendly

Other_____

Are there any social or emotional characteristics or behavior about which you are concerned? If yes, please describe _____

_____

_____

What are your child's favorite toys, objects and activities? _____

_____

_____

How does your child play with other children? _____

_____

X. LANGUAGE

A. RECEPTIVE LANGUAGE – UNDERSTANDING LANGUAGE

1. Approximately how many words does your child understand? _____
2. Does your child identify body parts (ears, eyes, nose, chin, etc.)? _____
3. Does your child follow one-step commands involving two objects (i.e. "Give me the cup and shoe")? _____
4. Does your child follow two-step directions involving two objects (i.e. "Open the door and give me the paper")? _____
5. Does your child respond to the following question forms?

   What? _____ Who? _____

   Where? _____ When? _____

B. EXPRESSIVE LANGUAGE – GESTURAL/VERBAL EXPRESSION

1. Children communicate in a variety of ways. Listed below are a number of behaviors your child may be using to convey a meaning to you. From the examples below, check the behaviors your child typically used to communicate and indicate how often.

BEHAVIORS	*How often?*			
	Frequently	*Sometimes*	*Rarely*	*Never*
☐ Smile				
☐ Tantrums				
☐ Cry				
☐ Points				
☐ Special cry with special meaning				
☐ Uses pictures				
☐ Looks at object/person				
☐ Change in body posture/movement				
☐ Looks away				
☐ Formal sign language				
☐ Looks from person to object				
☐ Shakes head yes/no				
☐ Facial expression				
☐ Sounds other than cry or words				
☐ Reaches				
☐ Uses own words, sounds consistently				
☐ Walks to object/person				
☐ Brings/Pulls you toward object				
☐ Grabs/picks up object				
☐ Gives you object				
☐ Uses single words/approximations				
☐ Uses 2 - 3 word/approx phrases				
☐ Uses 3 - 5 word phrases				

If your child does not talk, how does he/she let you know what he/she or wants? _____

_____

If your child does not use words to communicate what he/she wants, what do you do? _____

_____

What percentage of your child's words do you understand? _____

What percentage of your child's words would an unfamiliar listener understand? _____

If you don't understand what your child is saying what do you do?_____

_____

Does your child ask questions? Please give two examples. _____

_____

Does your child relate immediate experiences to another member of the family?_____

_____

Does your child use any two-word combinations (i.e. "more milk," "mommy up"): How often?_____

List examples:_____

More than three-word combinations? Give examples _____

_____

XI. MOTOR SKILL DEVELOPMENT (Coordination)

Have you observed any problems in your child's balance, walking, running, or using stairs? ____ If yes, please explain:

_____

Do you have any concerns about your child's eye-hand coordination for opening containers, manipulating clothing fasteners, or using a pencil? _____ If yes, please explain_____

_____

XII. SELF-HELP SKILLS

Describe your child's mealtime skills, including utensil use and the amount of adult assistance required: _____

_____

Describe your child's undressing and dressing skills, including the amount of adult assistance required: _____

_____

If your child is not yet toilet-trained, please describe what his/her experience with toilet training has been: _____

_____

Is there anything else that has not been covered in this questionnaire that you feel is important for us to know? _____

_____

_____

_____

Thank you for helping us better understand your child. We look forward to meeting with both you and your child.

This form was completed by _____ Date _____

Relationship to child:_____