Parent Interview

Kindergarten – 12th Grade

I. **PERSONAL DATA** SSN and MSIS:

A. Child's Name	B. Date of Birth	C. Age	D. Gender
E. Child's Address		Phone #	
F. Child lives with:	Email address:		
G. Referred by	H. Informant for this history:		

II. **HOME AND FAMILY INFORMATION**

A. *Mother* – 1. Full Name		2. Age
3. Highest level of education completed	4. Occupation	
5. Employer	6. Work Phone	
B. *Father* – 1. Full Name		2. Age
3. Highest level of education completed	4. Occupation	
5. Employer	6. Work Phone	

C. Marital Status of Parents:	Married	Divorced	Separated	Single

D. Others Living in the Home:

Name	*Age*	*Sex*	*Relationship*
1.			
2.			
3.			
4.			
5.			
6.			

E. Native Language Spoken in the Home

F. Does the child receive Medicaid?

G. If the child was adopted, what age was the child when you adopted and what previous history do you know about the child?

Describe any of the child's behavior(s) that is a problem:

With which hand does the child draw or write? Throw a ball?

What does your child enjoy doing most?

What are some things that your child does well?

Does the child require a special diet?

As compared to other children, did this child sit up, crawl, and/or walk early, late, or at the same approximate time as peers?

Child's Name: _____

Has the child ever been seriously ill or injured?
Is the child allergic to anything?
Has the child ever had a seizure, fainted, or passed out?

III. **EDUCATIONAL BACKGROUND**

A. 1. Present School	2. Phone
3. Address	
4. Teacher	
C. Did your child have any problems with peers, teacher(s), learning activities ☐ YES ☐ NO If so, describe:	
D. If your child did not attend school, who took care of him/her?	
E. Has your child been tested previously? ☐ YES ☐ NO If so, how can we obtain these results?	

IV. **MEDICAL/PHYSICAL INFORMATION**

A. Were there any complications during the pregnancy? ☐ YES ☐ NO Explain:
B. Any Childhood Diseases? ☐ YES ☐ NO Circle: chickenpox, mumps, measles, Other:
C. Describe any health problems your child has.
D. Are there any medical reports available? ☐ YES ☐ NO If so, how may we obtain them?
E. Has your child ever received services, i.e. speech therapy, PT/OT? ☐ YES ☐ NO Describe:
F. Does your child take any medication(s)? ☐ YES ☐ NO If so, what and for what reason?
G. Hearing 1. Does your child's hearing seem to be normal? ☐ YES ☐ NO If abnormal, explain:

Child's Name: _____

2. Does your child have frequent ear infections?	☐ YES	☐ NO	How often?
Does your child have ear tubes?	☐ YES	☐ NO	When?
3. Has your child's hearing ever been tested? When?	☐ YES	☐ NO	Where?
Does your child wear hearing aids? ☐ YES ☐ NO	Results? For how long?		

H. Vision

1. Does your child's vision seem to be normal? If abnormal, explain:	☐ YES	☐ NO
2. Has your child had a visual examination? Where?	☐ YES	☐ NO
3. Does your child wear glasses?	☐ YES	☐ NO

I. Motor Skills

1. Does your child exhibit any gross motor problems (i.e. difficulty walking, hopping, jumping, running) as compared to other children his/her age? Describe:	☐ YES	☐ NO
2. Does your child exhibit any fine motor problems (i.e. stacking blocks, buttoning, cutting, zipping) as compared to other children his/her age? Describe:	☐ YES	☐ NO

V. **SOCIAL**

A. Does your child do what adults tell him/her to do?	☐ YES	☐ NO
B. Explain how your child gets along with: a) Siblings: b) Other children: c) Adults:		
C. Does your child seem to enjoy:		
a) Playing alone?	☐ YES	☐ NO
b) Playing with other children?	☐ YES	☐ NO
c) Being with adults?	☐ YES	☐ NO
D. Does your child make friends easily?	☐ YES	☐ NO

E. Self-help Tasks (Check only those tasks that the child can perform independently)

☐ Dries self with towel	☐ Puts on socks	☐ Buckles belt
☐ Feeds self with fork	☐ Puts shoes on correct feet	☐ Toilet trained at night
☐ Holds cup by hands	☐ Dresses self completely except tying	☐ Toilet trained during day
☐ Brushes teeth	☐ Removes coat/shirt with front opening	☐ Puts on/pulls up pants

VI. LANGUAGE AND SPEECH

A. Does your child seem to understand what is said to him/her?	☐ YES	☐ NO
B. Can you understand what your child says? If not, why?	☐ YES	☐ NO
C. Can others understand what your child says? If not, why?	☐ YES	☐ NO

D. How often does your child use speech?	☐	Frequently	☐	Occasionally	☐	Never

E. Does your child prefer speech or gesture?		Speech		Gesture

F. Describe any additional language or speech problems.

VII. COGNITIVE

A. Can your child tell you:

a) His/her name? ☐ YES ☐ NO
b) His/her age? ☐ YES ☐ NO
c) His/her gender? ☐ YES ☐ NO
d) His/her address? ☐ YES ☐ NO

B. Compared to other children of your child's age, does your child:

- ☐ Look at books independently?
- ☐ Enjoy being read to?
- ☐ Count three objects?
- ☐ Identify differences between tall, short, little, big?
- ☐ Count to three?
- ☐ Count to ten?
- ☐ Point to colors when named?

VIII. ADDITIONAL INFORMATION

A. Please provide any additional information that will help us to understand your child better.

B. What is the best day and time to contact you?

C. What is the best day and time to arrange a meeting with you?

D. INTERVENTIONS (In-school Preschool Ages 3-5 not enrolled in Kindergarten)
If interventions were conducted, attach intervention documentation. If a team determined it to be inappropriate to conduct interventions, state reason(s) below.

Form Completed by:	Date Completed: