

Downtown Jewish Preschool #6 PARENT QUESTIONNAIRE



Date _____
CHILD'S NAME _____ Present age _____ DOB _____

DEVELOPMENTAL HISTORY

Type of birth: Normal _____ Premature _____ Any complications? _____
 Please explain _____
 Age child began sitting _____ crawling _____ walking _____
 Does child fall easily? _____
 Age child began talking _____
 Current language abilities _____
 Primary language spoken at home _____ secondary _____
 Do you have any concerns about your child's speech? _____
 Explain: _____
 List past major illnesses or physical conditions _____

 List any accidents, operations, or hospitalizations (and dates) _____

Does your child now (or has your child in the past) receive any of the following services:

	Provider	Phone
___ Occupational Therapy	_____	_____
___ Physical Therapy	_____	_____
___ Speech Therapy	_____	_____
___ Behavioral Therapy	_____	_____

Have any of the above services ever been recommended for your child? _____
We would like to be able to work with or consult any privately hired specialist working with your child so that we can reinforce skills and techniques used in therapies. Please sign below that we have permission for open communication. Each service provider must register at our front office before meeting with a child. They must sign a letter of confidentiality.

Signature: _____ Date: _____

SLEEPING HABITS

What is your child's normal bedtime? _____
 What is a normal waking time for your child? _____
 Does your child have any trouble sleeping or falling asleep? _____
 Does your child nap during the day? _____ How long? _____
 Does your child have a favorite nap time toy? _____
 Are there any concerns about your child's sleep habits? _____

EATING HABITS

Does your child have any known food allergies? _____
 What reaction should we expect? _____
 Insect bite allergies? _____
 What reaction should we expect? _____
 Does your child enjoy eating? _____

Does your child feed him/herself? _____ spoon? _____ fork? _____
Are there any concerns about your child's eating habits? _____

BATHROOM

Please note that toilet training is not a criteria for enrollment.

Is your child toilet trained for urine? Y | N For bowel movements? Y | N

What word is used for urination? _____ for bowel movements? _____

Do accidents occur? Y | N How often? _____

Does your child need help in the bathroom? _____ To what extent? _____

SOCIAL AND EMOTIONAL BEHAVIOR/EXPERIENCES

Has your child had experience playing with other children? _____

Has your child been in a formal school setting? _____

If so, when and where? _____

What activities does your child enjoy? _____

Does your child tend to play with children who are older | younger | same age ?

Does your child enjoy playing alone? Y | N

What makes your child angry or upset? _____

How does your child express anger, frustration, or disappointment? _____

How does your child react to change? _____

How does your child relate to new people? _____

What do you find is the best way to relate to your child when he/she is upset? _____

How do you discipline your child at home? _____

Is it difficult for your child to separate from you? _____

All children experience stages of development and behavior. We are primarily interested in knowing about any regular patterns of behavior which your child frequently demonstrates. Please circle...

cries easily

temper tantrums

thumb sucking

active

fearful

independent

quiet

easy going

excitable

daydreams

calm

friendly

willful

happy

shy

impulsive

cooperative

aggressive

Is there any additional information that could help us to make preschool a positive experience for your child? *(Please feel free to use a separate sheet of paper)*

Thank you for taking the time to fill out this questionnaire.