Early Childhood Family 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.

Child's Name: _____ Date of Birth: _____

What languages are spoken in the home? _____

General

Tell us about your experiences with and observations of 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 your child special?

Practical Life at Home

Tell us about your child's routines and general skills

1. What is your child's normal bedtime? Where do they usually fall asleep (in their bed, in your bed, in your arms, on the sofa…)?

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

3. Does your child normally take a nap during the day? If so, how long do they normally sleep?

4. What does your child normally eat for breakfast?

5. What does your child like to eat most?

6. Are there any foods that they will not eat?

7. Does your child feed him or herself?

8. Does your child dress him or herself?

9. Does your child use the toilet independently? If not, please tell us where they are in this process.

10. 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 (i.e. premature birth, low birth weight, etc.)?

2. Was your child more than 3 weeks premature?

   ☐ Yes ☐ No

3. Have you ever suspected that your child has vision problems?

   ☐ Yes ☐ No

   If yes, please explain:

4. Have you ever suspected that your child has hearing problems?

   ☐ Yes ☐ No

5. If yes, please explain:

6. Has your child ever had trouble walking, climbing, reaching, holding on to things

   ☐ Yes ☐ No

7. If yes, please explain:

8. Does your child have allergies?

   ☐ Yes ☐ No

   If yes, please explain:

9. Is your child presently on any medications?

   ☐ Yes ☐ No

   If yes, please explain:

Child's Development

Can your child:

1. Feed him or herself using a spoon and/or a fork?

   ☐ Yes ☐ No

2. Speak so that they can be understood by others?

   ☐ Yes ☐ No

3. Express their thoughts and needs easily?

   ☐ Yes ☐ No

4. Toilet independently during the day?

   ☐ Yes ☐ No

5. Does your child:

   Use crayons and/or markers to scribble or draw?

   ☐ Yes ☐ No

   Listen to stories being read?

   ☐ Yes ☐ No

   Recall stories or events?

   ☐ Yes ☐ No

   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: _____