MOORESTOWN TOWNSHIP PUBLIC SCHOOLS
Child Study Team
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PRESCHOOL QUESTIONNAIRE
TO BE COMPLETED BY THE CHILD'S PARENT OR GUARDIAN

Your answers to the following questionnaire will assist us in obtaining an accurate and complete history of your child. This will enable us to focus our evaluations on areas of concern for your child's developmental/educational needs.

Child's Name:_____
DOB:_____
Gender: _ _M /_ _F

Mother's Name:_____ **Occupation:**_____

Father's Name:_____ **Occupation:**_____

Guardian's Name:_____ **Occupation:**_____
(if applicable)

Who presently resides in the household:_____
_____
Language spoken in home:_____
Name of child's primary physician:_____
Date of last check-up:_____
Medications: _____

Nursery School or Daycare:_____
Contact person/phone number:_____
Number of Hours/ Days per week:_____

Please check the appropriate answer to the following questions. If **you are unsure of an answer, please circle the question mark so that we may follow up with additional questions. Y = Yes, N = No, ? = Unsure**

Pregnancy and Delivery:

Were there any difficulties during this pregnancy? ___Y ___N ___?

Did mother see a physician or attend a clinic regularly? ___Y ___N ___?

Was the baby carried to full term? ___Y ___N ___?

How much did the baby weigh at birth/length? _____

Were there problems during labor or delivery? ___Y N ?

Type of delivery? _____

Were there concerns about the baby at birth? Y N ?

Did the baby have difficulties in the nursery? ___Y ___N ___?

Did the baby come home from the hospital with the mother? ___Y ___N ___?

Any feeding issues (problems with sucking, swallowing, drooling)? ___Y ___N ___?

Health History:

Has your child:

Ever been hospitalized? Y N ?

Had other serious illnesses, accidents, or injuries? ___Y ___N ___?

Taken any poisons or medications accidentally? ___Y ___N ___?

Had tonsils removed? Y N ?

Ever had significant head injury? Y N ?

Broken any bones? ___Y N ?

Had convulsions and/or seizures? ___Y ___N ___?

Does your child have any food allergies? Y N ?

Does your child exhibit hay fever/allergies? Y N ?

Does your child seem to have a constant cold/stuffy nose? Y N ?

Has your child had an ear infection? Y N ?

How many times: _____

Has your child ever had fluid drained from the ears? Y N ?

Have tubes been inserted in your child's ears? ___Y ___N ___?

Does your child hear well? ___Y ___N ___?

Has their hearing been checked? ___Y ___N ___?

Does your child see well? Y N ?

Has vision been checked? ___Y ___N ___?

Should your child be wearing glasses? ___Y ___N ___?

Do your child's eyes ever cross? Y N ?

Any dental/ orthodontic concerns ___Y ___N ___?

Is your child potty trained? Y N ?

Please explain:_____

Does your child wet the bed? ___Y ___N ___?

Does your child have daytime accidents? Y N ?

Which of the following have been problems (Please Check):

___Drooling	___Falling	___Temper Tantrums	___Trouble Sleeping
___Cries Constantly	___Lying	___Clumsiness	___Nightmares
___Fighting	___Stealing	___Overactive	___Nail-biting
___Clinging	___Overly Shy	___Easily Upset	___Thumb-sucking
___Bad Temper	___Stuttering	___Can't Toilet Train	___Nervous
___Cannot Sit Still	___Breaking Things	___Speech is Unintelligible	
___Poor Focus	___Easily Distracted	___Does Not Understand what is said to them	
___Biting			

Developmental Milestones:

Did your child sit up independently by 9 months? ___Y ___N ___?

Did you child walk independently by 15 months? ___Y ___N ___?

Could your child say intelligible words by 18 months? Y N ?

Could your child put sentences together by three years? Y N ?

Does your child understand what people say to him/her? Y N ?

Describe your child's communication:

Personality Style:

What are your child's favorite things to do?

What activities/toys does your child avoid?

Please list any community-based activities in which your child is involved.

Does your child like to be read to? Y N ?

Does your child like to be held? ___Y ___N ___?

Does your child over-react to loud noises? ___Y ___N ___?

Does your child play with others well? ___Y ___N ___?

Describe your child's relationship with caregivers:

Describe your child's relationship with other children:

Please describe a typical day with your child (eating and sleeping patterns, play, moods, communication):

My child's strengths are:

My child's weaknesses are:

Prior Interventions/Therapies:

Has your child received speech, occupational, or physical therapies? ___Y ___N ___?

Has your child been evaluated by any other person/agency for developmental, learning, speech/language, fine/gross motor, behavioral concerns, or medical concerns? ___Y ___N ___?

If so, where and when?:_____

What were their findings?: _____

Family History Information:

Please answer the following questions:

Name	Age	Sex	Health Problems	Learning Problems
Mother _____	_____	_____	__Y __ N	__Y __N
Father _____	_____	_____	__Y __ N	__Y __N
1st born _____	_____	_____	__Y __ N	__Y __N
2nd born _____	_____	_____	__Y __ N	__Y __N
3rd born _____	_____	_____	__Y __ N	__Y __N

What goals do you have for your child?

Please provide any additional information that might be helpful.