# SAN LEANDRO UNIFIED SCHOOL DISTRICT

***Department of Special Services***

## EARLY INTERVENTION SERVICES

## PARENT QUESTIONNAIRE

*Please Print Legibly*

**I. IDENTIFYING INFORMATION** Today's date: ________________

Child's Name: ________________________ Birth date: __________ Age: ______ ☐ Male ☐ Female

Address: ______________________________ Zip Code: __________ Home School: ____________

Home Phone: ________________ Cell/Work Phone: ________________ email: ______________

Primary Language spoken at home: ____________________ / __________% child is exposed to language

Secondary Language spoken at home: ____________________ / __________% child is exposed to language

Language(s) Child speaks at Home: ______________________________________________

Other languages which the child is regularly exposed to : ______________________________

Who referred you to our program? ☐ Children's Hospital Oakland ☐ Kaiser ☐ Regional Center East Bay (RCEB)

☐ Other ____________________________

**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 affecting development? ☐ No ☐ Yes: If yes, please explain.

_____________________________________________________________________________

What strategies have you used to assist your child? ______________________________________

_____________________________________________________________________________

Please describe your child's daily routine. Give examples. ___________________________________

_____________________________________________________________________________

_____________________________________________________________________________

What is your families' mealtime routine? _____________________________________________

What is your child's bedtime routine? ________________________________________________

Do you give your child learning experiences outside of the home? ☐ No ☐ Yes

How often? How does your child respond?

Library: _______________________________________________________________________

Museums: ______________________________________________________________________

Other learning opportunities: ______________________________________________________

Do you have books at home or access to children's books? ☐ No ☐ Yes: If yes, how often do your read with your child?

☐ More than once a day ☐ Once daily ☐ Two to three times a week ☐ Less than two times a week

How much of your child's day is spent communicating with others (e.g., parents, the child's caregiver, siblings, family, peers)?

☐ Less than 25% ☐ 25-50% ☐ 51-75% ☐ More than 75%

What games do you play with your child?______________________________

How often do you play games together?

☐ More than once a day ☐ Once daily ☐ Two to three times a week ☐ Less than two times a week

**III. FAMILY HISTORY**

Mother's Name: ____________________ Age:________ Education level:____________________

Any learning, developmental, or health problems? If yes, please describe.____________________

______________________________

Father's Name :____________________ Age:________ Education Level:____________________

Any learning, developmental, or health problems? If yes, please describe.____________________

______________________________

| Names of Siblings | Age | School Attending/ Problems? |
| --- | --- | --- |
| ______________ | ______ | ______________________ |
| ______________ | ______ | ______________________ |
| ______________ | ______ | ______________________ |
| ______________ | ______ | ______________________ |

Are both parents living in the home? ☐ No ☐ Yes Who else is 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: How many weeks? ______ ☐ Overdue: How many days/weeks? ______

Prenatal Care Began at what month?______ ☐ Vaginal delivery ☐ Caesarean section ☐ Breech

Problems during birth?____________________________________________________________

Birth weight: ______________________ Length: ______________________ Apgar Score, if known:____________

Condition: ☐ Good ☐ Jaundice (yellow) ☐ Respiratory problems ☐ Feeding Problems

Problems/Treatment after birth? ☐ No ☐ Yes: If yes, please explain (e.g. oxygen, intubation, bilirubin lights, surgery, or extended hospitalization required?).____________________________________________

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 | ____________ | Weaned from pacifier | ____________ |
| 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 | ____________ |
| Pointed in order to request or draw attention to object | ____________ | Played peek-a-boo | ____________ |

Has your child lost any skills? Please describe in detail **what skills** were lost and **when**.______________________________

______________________________________________________________________________

## VI. HEALTH HISTORY

| Does child have a history of: | NO | YES | DESCRIBE (What/When?) | TREATMENT |
|---|---|---|---|---|
| Frequent colds | ___ | ___ | ____________ | ____________ |
| Ear infections | ___ | ___ | How Many?________ | ____________ |
| 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 #:______________Location:___________ 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? ☐ No ☐ Yes

Attends: (Mark each day they attend) Mon.___ Tues.___ Wed. ___ Thurs. ___ Fri. ___ Times :________to_____________

| DATES BEGAN & ENDED | PRESCHOOL/DAYCARE NAME | CHILD'S REACTION |
|---|---|---|
| | | |
| | | |
| | | |

## IX. SOCIAL-EMOTIONAL DEVELOPMENT

What are your child's strengths (what is your child good at)?

______________________________________________________________________________

______________________________________________________________________________

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

happy moody passive active alert irritable strong demanding withdrawn

flexible difficult to clam/soothe easy to care for aggressive shy anxious friendly

Other:______________________________________________________________________

Are there any social or emotional characteristics or behaviors that concern you? ☐ No ☐ Yes: If yes, please describe.

______________________________________________________________________________

______________________________________________________________________________

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

______________________________________________________________________________

Does your child only play with one type of toy? ☐ No ☐ Yes: If yes, what?______________________

How does your child play with other children? Please describe. ______________________________

______________________________________________________________________________

Does your child talk with other children? ☐ No ☐ Yes ☐ Tries to talk to other children

Do you have any concerns about your child's play skills? ☐ No ☐ Yes: If yes, please describe?__________

______________________________________________________________________________

Does your child engage in **pretend** or imaginative play? ☐ No ☐ Yes: If yes, please provide examples.__________

______________________________________________________________________________

Does your child frequently put non-food objects in his/her mouth? ☐ No ☐ Yes: If yes, what?______________

How does your child react to a change in his/her schedule? ☐ Flexible ☐ Needs some reassurance ☐ Tantrums

## 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.)? ☐ No ☐ Yes: If yes, about how many?__________

3. Does your child follow one-step commands involving two objects (i.e. "Give me the cup and shoe")? ☐ No ☐ Yes:

If yes, please provide an example.____________________

4. Does your child follow two-step directions involving two objects (i.e. "Open the door and give me the paper")?

☐ No ☐ Yes: If yes, please provide an example.____________________

____________________

5. What type of questions does your child **respond** to?

What? ☐ No ☐ Yes  Who? ☐ No ☐ Yes  Where? ☐ No ☐ Yes  When? ☐ No ☐ Yes

### *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 something to you. Indicate how often your child typically uses the behaviors below to communicate.

| *BEHAVIORS* *How often?* | *Frequently* | *Sometimes* | *Rarely* | *Never* |
|---|---|---|---|---|
| Smile | _____ | _____ | _____ | _____ |
| Tantrums | _____ | _____ | _____ | _____ |

What does your child do when s/he tantrums?____________________

| *BEHAVIORS* *How often?* | *Frequently* | *Sometimes* | *Rarely* | *Never* |
|---|---|---|---|---|
| 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 | ________ | ________ | ________ | ________ |

Write 0-100% in the spaces below next to each person. What can each person understand the **first** time your child says something, without having to ask them to repeat or clarify themselves? **My child is non-verbal** ☐

| | | | |
|---|---|---|---|
| MOTHER= | % | GRANDPARENT= | % |
| FATHER= | % | STRANGERS= | % |
| SIBLING= | % | FRIENDS= | % |

**If or when** your child does not talk, how does s/he let you know what s/he or wants?________________________________

________________________________________________________________

If your child does not use words to communicate what s/he wants, what do **you** do?________________________

________________________________________________________________

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

________________________________________________________________

Does your child get frustrated when not understood? ☐ No ☐ Yes: If yes, what does s/he do?______________

________________________________________________________________

What type of questions does your child **ask**?

What? ☐ No ☐ Yes Who? ☐ No ☐ Yes Where? ☐ No ☐ Yes When? ☐ No ☐ Yes

Why? ☐ No ☐ Yes How? ☐ No ☐ Yes

Please give two examples:________________________________________________

________________________________________________________________

Does your child talk about things that are happening or that recently happened to other members of the family or peers?

☐ No ☐ Yes: If yes, please provide an example:______________________________________

Does your child use any two-word combinations (i.e. "more milk," "mommy up")? ☐ No ☐ Yes

How often?______________ List examples:________________________________________

Does your child use any three-word combinations (i.e. "I want ____," "I like___")? ☐ No ☐ Yes

How often?______________ List examples:________________________________________

## XI. MOTOR SKILL DEVELOPMENT (Coordination)

Have you observed any problems in your child's balance, walking, running, or using stairs? ☐No ☐Yes: If yes, explain:

________________________________________________________________

Do you have any concerns about your child's eye-hand coordination for opening containers, manipulating clothing fasteners, or using a pencil/crayon? ☐ No ☐ Yes: 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: ___________________

___________________________________________________________________________

Is your child toilet-trained? ☐ No ☐ Yes (☐ Urine ☐ Bowel) ☐ Some accidents ☐ Child is interested in toileting

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

___________________________________________________________________________

Does your child follow rules (e.g. cleaning up toys when asked, listening to an adult's directions, etc.)?_☐ No ☐ Yes

**XIII. ATTENTION SPAN**

Is your child able to sit independently and play with a toy? ☐ No ☐ Yes

For ☐5 minutes or less ☐10 minutes ☐15 minutes ☐20 minutes ☐Longer (how long?) _____________

Is your child able to sit and read a book on his/her own? ☐ No ☐ Yes

For ☐5 minutes or less ☐10 minutes ☐ 15 minutes ☐20 minutes ☐Longer (how long?) _____________

Is your child able to sit and have someone read to him/her? ☐ No ☐ Yes

For ☐5 minutes or less ☐10 minutes ☐15 minutes ☐20 minutes ☐Longer (how long?) _____________

Which seems to be your child's preferred choice? ☐ TV ☐ DVD (movies) Examples:____________________

___________________________________________________________________________

Does s/he prefer to watch the same show or DVD movie over and over, or does s/he like the **variety** of daily TV episodes or different DVDs? ___________________________________________

Is your child able to sit and watch TV/DVDs on his/her own? ☐ No ☐ Yes

For ☐5 minutes or less ☐10 minutes ☐15 minutes ☐20 minutes ☐Longer (how long?) _____________

Is s/he able to sit in a group of children (e.g., circle time, story time at library, present time at birthday parties, etc.)?
☐ Yes ☐ No For ☐5 minutes or less ☐10 minutes ☐15 minutes ☐20 minutes ☐Longer (how long?)___________

Have you completed a Residency Verification with San Leandro Unified School District? ☐ No ☐ Yes

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

___________________________________________________________________________

___________________________________________________________________________

***Thank you for taking the time to fill out this entire survey. This information will help 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:___________________________________________________________________

Best phone number to reach you:___________________________________________________________