NORTHEAST COLORADO
"Every Student, BOCES Every Day"
BOARD OF COOPERATIVE EDUCATIONAL SERVICES
301 W. Powell * PO Box 98, Haxtun, CO 80731 * 970-521-2771

PARENT QUESTIONNAIRE (Preschool)

This information is CONFIDENTIAL and will be used by BOCES staff and appropriate School Staff for assessment and educational planning. *If completing in fillable format, you will need to save it to your computer prior to making changes, fill in questions, save again to your computer, then e-mail/fax to the designated person.*

CHILD'S LEGAL NAME _____ DATE OF BIRTH_____

ADDRESS _____

PLACE OF BIRTH _____ LENGTH OF TIME IN USA _____

NAME OF SCHOOL _____ TEACHER'S NAME(S) _____

NAME OF PERSON COMPLETING THIS FORM _____

YOUR RELATIONSHIP TO THIS CHILD _____

Child Strengths and Interests _____

What is your child good at and like to play with?_____

_____

What does your child like? _____

_____

What does your child dislike? _____

_____

Parent Information_____

Mother's name _____ Stepmother? ☐ No ☐ Yes
Language(s) spoken (primary listed first) _____
Address _____ City_____ Zip Code _____
Cell Phone _____Work Phone _____ E-mail Address _____
Occupation _____ Employer _____
How long with present employer _____ Highest Grade completed _____

Father's name _____ Stepfather ? ☐ No ☐ Yes
Language(s) spoken (primary listed first) _____
Address _____ City_____ Zip Code _____
Cell Phone _____Work Phone _____ E-mail Address _____
Occupation _____ Employer _____
How long with present employer _____ Highest Grade completed _____

Other custodial parent (If applicable) _____Language(s) spoken _____
Address _____ City_____ Zip Code _____
Cell Phone _____Work Phone _____ E-mail Address _____
Occupation _____ Employer _____
How long with present employer _____ Highest Grade completed _____

Family History _____

Please list all persons living in the home (including grandparents, aunts, etc) and other siblings not in home:

Name	Age	Relation to student	Present school and grade, or highest grade completed	If a sibling, are they in this home most or all the time?	Language(s) Spoken
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Has this child ever experienced any parental separations, moves, divorces, death of close family members, other traumatic experiences, or other major life changes? ☐NO ☐YES

- If yes, When (month/year(s))? _____
- How old was this child at the time? _____
- Please describe the circumstances. _____

If parents are separated or divorced, who has physical custody of this child? _____

- Is there a joint custody agreement between parents? ☐NO ☐YES
- How often does the other parent see this child? _____
- Which parent has educational decision making rights? _____

Please check the corresponding box if any close biological members of the family have a condition listed below. If yes, please indicate the person's relationship to the child in the blank box to the right.

check		relationship	check		relationship
☐	Attention Deficit Hyperactivity Disorder		☐	Autism	
☐	Learning Difficulties in School		☐	Developmental Delays	
☐	Speech or Language Concerns		☐	Anger Management Issues	
☐	Depression/Anxiety		☐	Alcohol and/or Drug Abuse	
☐	Other Psychological Disorders		☐	Other Disorders that impacted education	

Please mark other agencies involved in your child's life.

☐ Social Services Contact Person: _____
☐ Centennial Mental Health Contact Person: _____
☐ Eastern Colorado Services Contact Person: _____
☐ Children's Hospital Contact Person: _____
☐ Other Contact Person: _____

Please List all past/current treatment interventions (speech-language, psychology, ABA Therapy, occupational therapy, physical therapy, etc) for this child. _____

_____

_____

Child Care/Pre-School History _____

If primary caregivers work outside the home, please answer the following two questions.
How many hours per day is this child in a child-care setting? _____
How many different people care for this child? _____ Please explain _____
Does or did this child attend preschool? ☐ NO ☐ YES At what age did they start? _____

School Name	Location	Grade(s) Attended	Hours per day	Days per week	Language of Instruction

Any problems in school or daycare? ☐ NO ☐ YES If yes, explain _____
Does your child like going to school/daycare? ____ If no, describe the behaviors exhibited an when. _____
_____

Please list the amount (time) and types of exposure to preschool type activities in the home per day. _____
_____

Does your child excel at certain academic skill areas? _____ If yes, explain which areas. _____

What are your concerns about your child's school performance? _____
_____

When did these concerns begin? _____Was there a triggering event?_____
_____

Social Relationships_____

How does your child get along with brother (s) and/or sister (s)? _____
How does your child get along with parents? teachers? other adults? _____

Generally Compliant	☐ NO	☐ YES
Fights frequently with playmates/peers	☐ NO	☐ YES
Prefers playing with younger children	☐ NO	☐ YES
Has difficulty making friends	☐ NO	☐ YES
Prefers to play alone or be alone	☐ NO	☐ YES

What role does this child take in peer group games or social interactions (for example, passive, leader, follower, aggressor, etc.)? _____

Social Emotional Behavioral Concerns _____

Do any of these behaviors describe your child?

Demonstrates excessive temper tantrums	☐ NO	☐ YES
When excited has a hard time calming down	☐ NO	☐ YES
Doesn't pay attention well for their age	☐ NO	☐ YES
Has difficulty starting a task or shifting to another task	☐ NO	☐ YES
Has difficulty stopping when told to	☐ NO	☐ YES
Seems unhappy most of the time	☐ NO	☐ YES
Withholds affection	☐ NO	☐ YES
Requires a lot of parental/adult attention	☐ NO	☐ YES
Has excessive fears	☐ NO	☐ YES

Has difficulty recognizing other people's emotions ☐NO ☐YES
(i.e. smile means happy, scowl means mad)
Is sensitive to sounds, taste, or touch? ☐NO ☐YES
If yes on any of the above behaviors, please describe _____

Speech and/or Language _____

Do you have concerns about your child's speech? ☐NO ☐YES
Did your child acquire language before the age of 3? ☐NO ☐YES
How well do others understand your child? _____
Do you often have to explain to others what your child is saying? If so, how? _____
Does your child use sentences that make sense? ☐NO ☐YES
Does your child answer simple questions? ☐NO ☐YES
Does your child make eye contact with you and others? ☐NO ☐YES
Does your child enjoy making family members laugh (makes silly faces or noises)? ☐NO ☐YES

Is your child frequently exposed to more than one language? ☐NO ☐YES

- If Yes, what language (s)_____
- Which language did they learn first (primary)? _____
- What age were they when exposed to the second language _____
- What language(s) does your child use with family? _____
- Language used with friends? _____

Early Childhood Adaptive/Developmental Milestones _____

Extremely fussy and temperamental as a baby ☐NO ☐YES
Diagnosed with failure to thrive? ☐NO ☐YES
Had irregular sleeping habits (woke often: talked in sleep) ☐NO ☐YES
Did new or infrequent situations lead to temper tantrums
(holidays, visits to relatives, unusual feeding times) ☐NO ☐YES
Rocked and banged the crib? ☐NO ☐YES
Had excessive difficulties separating from parents after 3? ☐NO ☐YES
Please describe feeding difficulties (if any): _____

Check next to the skill if your child showed the skill within the normal developmental timeline.

☐	Rolled over	☐	Sit up independently	☐	Crawl
☐	Walk alone	☐	Walk up and down stairs	☐	Toilet Trained
☐	Fed self	☐	Dress self	☐	Groom self
☐	Understands yes and no	☐	Said "mama" "dada" with meaning	☐	Speak in sentences -4 words or more
☐	Apologizes	☐	seeks out others to play	☐	Plays with others
☐	Counts	☐	flip through/read books	☐	uses a pencil

Were there any losses of these skills at any time? If yes, please explain. _____

_____

Medical History _____

Family Medical History

Please mark yes or no if any biological members of the family have any of the conditions listed below. If yes, please indicate the person's relationship to the child.

Yes	No	Medical Condition	Relationship		Yes	No	Medical Condition	Relationship
☐	☐	Cancer			☐	☐	Diabetes	
☐	☐	Heart Disease			☐	☐	High Blood Pressure	
☐	☐	Kidney Disease			☐	☐	Migraine Headaches	
☐	☐	Bleeding Disorders			☐	☐	Muscular Dystrophy	
☐	☐	Tourette's Syndrome			☐	☐	Genetic Disorder	
☐	☐	Seizures / Epilepsy			☐	☐	Other:	

Pregnancy

Did Mother of the Child obtain prenatal care? ☐Yes ☐No

If so, when? ○Beginning ○ Middle ○ End

Were there any medical problems experienced during this pregnancy? ☐Yes ☐No

if yes, please explain _____

Did Mother use any marijuana or alcohol before or during pregnancy? ☐Yes ☐No

If yes, please explain:_____

Did Mother use any drugs (prescription or non prescription) before or during pregnancy? ☐Yes ☐No

How long was the pregnancy in weeks? _____ weeks

Birth

How was the child delivered? (Check one:)

○Normal Vaginal Birth ○Scheduled Cesarean Section ○Emergency Cesarean Section

What was the Birth weight: _____ lbs _____oz

	Yes	No	
Were there any problems during delivery?	☐	☐	Explain:
Was your child Jaundiced (yellow-coloring of skin)?	☐	☐	Explain:
Did your child require Bilirubin lights?	☐	☐	For how long?
Did your child have any breathing problems?	☐	☐	Explain:
Did your child require supplemental oxygen?	☐	☐	For how long?
Did your child have a newborn hearing screening?	☐	☐	Results:

Current Medical Status

Is your child covered by:

⊙Medicaid ○ Child Health Plan Plus (CHP+) ○Private Insurance ○No Health Insurance

In the past year my child's health has been: ○Great ○Good ○Fair ○ Poor

How many school days has your child missed due to illness in the past year: _____

	Yes	No	
Does your child receive regular medical checks?	☐	☐	Child's family Physician:
Has your child had any significant accidents or injuries?	☐	☐	Explain:
Has your child been diagnosed with any medical problem? (Examples:Asthma, Diabetes, Seizures, etc)	☐	☐	Explain:

	Yes	No	
Has your child been diagnosed with any psychological conditions? (Examples: Anxiety, Depression, ADHD, etc)	☐	☐	Explain
Has your child had any serious illnesses, hospitalizations or surgeries?	☐	☐	Explain:
Does your child receive dental care?	☐	☐	Child's Dentist:
Do you have any dental concerns for your child?	☐	☐	Explain:
Has your child ever been diagnosed as being underweight?	☐	☐	Explain:
Has your child ever been diagnosed as being overweight?	☐	☐	Explain:
Is your child allergic to any medications?	☐	☐	Explain and describe reaction:
Is your child allergic to any foods?	☐	☐	Explain and describe reaction:
Does your child require the use of Benadryl or Epinephrine for any allergies?	☐	☐	Explain and describe reaction:
Does your child receive routine eye examinations?	☐	☐	Eye Physician:
Does your child have any past or present eye problems?	☐	☐	Explain:
Does your child wear contacts or glasses?	☐	☐	Date of most recent Exam:
Is there anyone in the family with a hearing loss? **(not from aging)**	☐	☐	Explain:
Has your child ever been diagnosed with a hearing problem?	☐	☐	Explain:
Do you have any hearing concerns for your child?	☐	☐	Explain:
Does your child have ear infections? Did they have ear infections as a child?	☐	☐	Age of first? How many per year?
Did your child require ear tube placement?	☐	☐	When were they inserted? Did they have to be replaced?
Has your child ever had a hearing test or evaluation?	☐	☐	When? With Whom? Results?
Is your child currently on any routine medications?	☐	☐	Who is the prescribing doctor?

Please list and answer the following about the medications:

Medication	**Dose**	**Times given?**	**Why prescribed?**	**When started taking it?**	**Improvement since taking?**	**Noticed side effects?**

Thank you very much for the time and effort in completing this form!

_____ _____

Signature of person completing this form **Date**