Parent Questionnaire

Early Kindergarten Evaluation

Today's Date: _____

Form Completed by: _____ , (the child's _____)

Child's Full Name: _____ **Date of Birth**:_____ **Age**:___

Parents: Mother _____ **Father** _____

Languages spoken in the home: Primary _____ Others_____

Who does the child currently live with (please include siblings)?

Name	Age	Relationship to Child

ACADEMIC HISTORY ☐ Not Currently Enrolled

Daycare:

Preschool Name: _____ Full Time/Part Time: _____

Does he/she participate in any other educational experiences?

Does he/she receive any special assistance in any of the previously mentioned programs?

Pre-reading/Reading – Is your child:

Reciting the alphabet alone? _____

Identifying letters? _____

Reading any sight words? _____

Please provide any other relevant information regarding your child's experiences/abilities with reading:

Pre-math/Math:

How high can your child count without prompting?

Is he/she able to identify numbers?

Is he/she able to do any addition/subtraction?

Is he/she able to do any multiplication/division?

Please note any other relevant information regarding your child's experiences/abilities with math:

Please describe your child's relationship with peers:

Please describe your child's relationship with teachers/authority figures:

Are there any concerns regarding your child's behaviors at home or at school?

Are there any concerns regarding your child's ability to maintain attention/concentration?

What feedback have teachers/staff given you regarding your child at school/daycare?

Do teachers/staff feel your child is ready to attend Kindergarten? Why?

Strengths (Academic): _____

(Personal): _____

Challenges (Academic): _____

(Personal): _____

Has your child participated in any testing in the past?
If so, please elaborate and specify which tests were used.

DEVELOPMENTAL HISTORY: ☐ Developmental History Unknown

Were there any medical problems during pregnancy/delivery? ☐ Yes ☐ No
If so, please describe:

Was your child born on time? ☐ Yes ☐ No
If not, at how many weeks gestation? _____

Did your child meet developmental milestones on time/early/with delays? _____
Walking at age _____
Speaking single words by age _____ Sentences by age _____
Potty trained by age _____
Please note any other relevant developmental issues here:

History of speech or occupational therapy? ☐ Yes ☐ No
If so, when/ where?

MEDICAL/MENTAL HEALTH HISTORY

How is your child's general health?

Are there any concerns with your child's vision? _____ Hearing? _____ Fine or Gross Motor Skills? _____

If so, please explain: _____

Please note any history of:

☐ Physical Disabilities ☐ Asthma ☐ Head Injury ☐ Loss of Consciousness ☐ Stitches

☐ Broken Bone ☐ Burns ☐ Overnight Hospitalizations ☐ Surgeries ☐ Seizures ☐ Allergies:

☐ Past Medications:

☐ Current Medications:

Please note any particular medical or mental health diagnoses: _____
Other relevant medical/mental health information: _____

****Please be sure your child sleeps and eats well prior to testing and bring a snack or drink, if he/she is likely to become hungry or thirsty during testing. ****

----------PLEASE COMPLETE THIS PORTION ON THE DAY OF TESTING----------

Please note any circumstances that may be of current/recent stress to your child:

Please note any circumstances that may affect today's testing (e.g., any medication taken, refusal to eat, very nervous about testing, etc…):