

2023 - 2024 Parent Intake Questionnaire

Dear Parents/Guardians:

Please take a few moments to introduce your child to us through this questionnaire. The information and answers that you provide enable us to better understand the whole child. **Information shared on this questionnaire will remain confidential and will only be shared with your child's classroom team.** We greatly appreciate your time in completing this form and look forward to working with you and your child. **Please print all information.**

Person completing this form: Mother Father Guardian Caregiver Other _____

Child's Name (First,Last): _____ Date of Birth: _____

Name child will be using in school: _____ Gender: _____

Living Information

1. Does your child have siblings? Yes (Please list below) No

Name of brother/sister	Age

Language

2. Does your child understand and speak English? Yes If yes, for how long? (years/months) _____

No (If no, please fill out ELL Questionnaire)

3. Language parents use most often: _____

School Situation

4. Briefly describe your child's previous school experience. _____

Home Situation

5. Have any of the following occurred?

Parents separated or divorced? Yes No If yes, when? _____

A death or major loss? Yes No If yes, who/when? _____

6. Has your child reacted to any of the above situations with behaviors that concern you? _____

7. Are there any family beliefs/traditions (religious or otherwise) that you would like the school to be aware of?

Health Information

8. Does your child wear glasses? Yes No

9. Has your child had ear tubes inserted? Yes No If yes, at what age? _____

10. Does your child have a significant medical history due to an accident, illness, or medical condition?

Yes No

If yes, please describe: _____

11. Has your child ever been hospitalized? Yes No If yes, please explain: _____
12. Does your child take prescription medications on a daily basis? Yes No
If yes, please list: _____
13. Does your child have any allergies or food/dietary restrictions? Yes No
If yes, please list allergies/food restrictions and reaction: _____
14. Has your child ever had any of the following assessments: (If yes, please check all that apply): Yes No
Cognitive or Developmental assessment Psychological assessment Neurological assessment
Early Intervention Special Ed

Speech/Language Information

15. Has your child had a speech and language evaluation. Yes No
If yes, did he/she receive therapy? Yes No Provider: _____
16. Child's Communication Skills (Check all that apply): No/Limited Verbal Uses single words Combines word
Names objects Asks simple questions Use full sentences

Sensory Information

17. Is your child fearful of crowds/loud noises? Yes No
18. Is your child a picky eater (does not like certain food textures, smells, etc.)? Yes No
19. Does your child become overwhelmed in new situations? Yes No.
20. Does certain clothing (tags, different materials, etc.) bother your child? Yes No
21. My child can hold a pencil and write with it. Yes No
22. My child has established hand dominance. Yes No
23. My child has established a tripod grip. Yes No
24. My child can cut with scissors. Yes No
25. My child can copy a horizontal line, a vertical line and a circular shape. Yes No
26. My child has had an occupational therapy and/or sensory evaluation. Yes No
If yes, did he/she receive therapy? Yes No For how long? _____

Attention Information

27. My child gives eye contact to the person speaking. Yes No
28. My child sticks to one activity for at least 5 minutes at a time (not including computer or t.v.). Yes No
29. My child perseverates or excessively over-focuses on things or ideas. Yes No

Self-help Information

30. My child can **independently**: (Check all that apply)
- Follow a 2-step direction
 - Take care of **all** toileting needs
 - Feed him/herself

31. Are there any eating problems that we should know about: Yes No If yes, please explain: _____

32. Is your child fully toilet-trained? Yes No If yes, at what age? _____

Social Development Information

33. My child initiates play with other children. Yes No
34. My child easily separates from parents. Yes No
35. My child gets along well with other children. Yes No
36. My child is fearful/anxious and worries a lot. Yes No

37. Does your child exhibit any serious behavior problems? (Check all that apply)

- Defiance of adults/non-compliant
- Excessive, long-lasting tantrums
- Biting
- Aggressive/violent behavior towards self/others
- Other: _____

38. What is your child's reaction to stress? _____

Discipline

39. Are there challenges with behavior management at home or school: Yes No If yes, what is the most effective in establishing acceptable behavior? _____

Parent Input

40. My child's strengths are: _____

41. Does your child have a formal diagnosis: Yes No If Yes, please specify: _____

42. Is there anything else you would like us to know about your child that we have not asked? _____

43. What time does your child go to bed/fall asleep/wake up? _____/_____/_____

44. Approximately how much tv/screen time does your child watch per day? _____

45. Please describe your expectations/goals regarding your child's experience at Learning Springs? _____

46. We encourage you as parents to be actively involved in the school community. How might you actively contribute?

- Volunteer
- Activities in school
- Attend field trips
- Room Parent
- Parent support group
- Story time with students
- School maintenance needs
- IT Support
- Library Help
- Other: _____

47. How did you hear about our program? (Check all that apply)

- Website
- Physician
- Word of Mouth
- Other Professional
- Walk in
- Phone Call
- Brochure/flyer
- Other _____

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian _____ Date: _____

Office use:

Director's Signature _____ Date _____

Classroom Staff: 1. _____ Date _____

2. _____ Date _____

Ass't Director's Signature _____ Date _____

3. _____ Date _____

FOR ENGLISH LANGUAGE LEARNERS ONLY
ENGLISH LANGUAGE LEARNER (ELL) PARENT QUESTIONNAIRE

1. How would you rate your child's ability to speak English?

- No English skills at current time
- Few words
- Few phrases
- Few sentences

2. How would you rate your child's ability to understand English?

- No English skills at current time
- Few words
- Few phrases
- Few sentences

3. If your child does not know English please print the word used in his/her primary language for the following words.

Potty_____	Come_____	Mother_____
Hurt_____	Snack_____	Father_____
Out_____	Sit_____	Home_____
In_____	Yes_____	No_____

Language exposure and language development

- 4. First language or languages learned by your child: _____
 - 5. What language is used most often at home? _____
 - 6. Who does your child converse with most often at home? _____
 - 7. At what age did your child begin to speak? _____
 - 8. Do you think your child understands the primary language? If no, what is the problem? _____
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9. Do you think your child speaks clearly in his/her primary language? If no, what concerns you most about this?

School history (if not born in the USA)

- 10. Did your child attend school before arriving in the United States? Yes No If yes, for how long? _____
 - 11. Did your child have difficulty in school before coming to the U.S.? Yes No If yes, describe: _____
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12. How many schools has your child attended in the United States? _____
How long (for each school)? _____

13. Is there anything else you would like us to know as we begin developing your child's English skills?
