Wadsworth
City Schools
Phone: 330.336.3571
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WADSWORTH CITY SCHOOLS
PRESCHOOL PARENT QUESTIONNAIRE

Name of child: ______________________________ Birthdate: __________

Address: ______________________________ Phone: ______________

Questionnaire completed by: ______________________________

Date Completed: __________

With whom does the child live (include all members of the child's household)? __________

____

List other family members not living at home. ______________________________

Has the child attended preschool or childcare? Yes ______ No ______

If yes, for how long, and where? ______________________________

Do you suspect your child has difficulty in any area listed below? If yes, please check those that apply.

Vision Yes ______ No ______ Hearing Yes ______ No ______

Glasses Yes ______ No ______

Please explain if you checked an area above. ______________________________

____

Date of vision screening performed by doctor: ________ Results: ______________

Date of hearing screening performed by doctor: ________ Results: ______________

When did your child learn to walk? ______________________________

When did your child say his/her first words? ______________________________

When did your child start talking in 2 word phrases? ______________________________

____

Approximately what percent of the time do you understand what your child says? __________

____

(Please continue to answer questions on Page 2)

Approximately what percent of the time do unfamiliar people understand what your child says?

____

____

Were there any complications during pregnancy or birth of your child? Yes ______ No ______

If yes, please explain: ____

____

Was your child's birth premature? Yes _______ No ________

If yes, please explain: ____

____

At birth, did the doctors express any concerns with the baby such as seizures or turning blue?

Yes ______ No ______ If yes, please explain: ______________________________

____

Has your child ever had any major injuries or hospitalization? Yes _______ No _________

If yes, please explain: ____

____

Does your child have any medical diagnoses? Yes _______ No _______

If yes, please explain: ____

____

Does your child take any medication? Yes ________ No _________

If yes, please describe: ____

____

Does your child have any allergies? Yes ________ No _________

If yes, please describe: ____

____

What are your child's favorite activities? _____________________________________

____