



Early Screening Inventory-Revised[™] Meisels et al.

Parent Questionnaire

Date _____

CHILD INFORMATION

CHILD'S NAME _____ Male Female

HOME ADDRESS Street _____ Apt _____

City _____ State _____ Zip _____

Phone (_____) _____ Date of Birth _____

Who is completing this Name _____
Parent Questionnaire?

Relationship to child _____

FAMILY

With whom has the child lived for most of the past year? _____

Other children in the family - How many older? _____ How many younger? _____

Other people living in the household _____

What language(s) are spoken at home? English Other (specify) _____

PRESCHOOL/CHILD CARE HISTORY

Has your child attended preschool/child care before? Yes No

If yes, for how long? 6 months 1 year 2 years more than 2 years

Name of child's present or most recent school _____

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MEDICAL HISTORY

Birth Were there any significant problems during pregnancy? Yes No
If yes, please explain:
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.....
.....

Was your child more than 3 weeks premature? Yes No

If yes, how many weeks premature?

Baby's birth weight

Did the baby stay in the hospital longer than the mother? Yes No
If yes, please explain:
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.....
.....

At the time of birth, did the baby — have seizures Yes No
turn blue? Yes No

Child's Health Since Birth **EYES** Has your child ever had trouble seeing? Yes No
Does your child hold books and objects close to his or her face? Yes No
Have your child's eyes ever looked crossed? Yes No
Have you ever suspected that your child has vision problems? Yes No
If yes, please explain:
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.....
.....

EARS Has your child had frequent ear infections? Yes No
Has your child ever had trouble hearing? Yes No
Have you ever suspected that your child has hearing problems? Yes No
If yes, please explain:
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.....
.....

COORDINATION Has your child ever had trouble walking, climbing, reaching, holding on to things? Yes No
If yes, please explain:
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.....

MEDICAL HISTORY (continued)

Child's Health

Since Birth continued

Has your child ever had any significant injuries or hospitalizations?

Yes No

If yes, please explain:

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Does your child have allergies?

Yes No

If yes, please explain:

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.....

Is your child presently on any medications?

Yes No

If yes, please explain:

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Please describe any other health concerns:

Yes No

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.....

SOCIAL, EMOTIONAL, AND SELF-HELP SKILLS

Can your child — feed him or herself using a spoon and/or a fork? Yes No

wash and dry his or her own hands? Yes No

help with dressing or dress with little assistance? Yes No

stay with a babysitter? Yes No

speak so that he or she can be understood by others? Yes No

express his or her thoughts and needs easily? Yes No

Do you have any concerns about your child's appetite or willingness to try different foods? Yes No

If yes, please explain:

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.....

CHILD'S DEVELOPMENT (continued)

Do you have any concerns about your child's sleeping patterns (going to bed with difficulty or waking often during the night)? Yes No

If yes, please explain:

Is your child — highly active? Yes No
very quiet? Yes No

Is your child — toilet trained during the day? Yes No
in need of help with toileting? Yes No

Does your child — play with blocks, boxes, cups, or other construction toys without help? Yes No
use crayons and/or markers to scribble or draw? Yes No
listen to stories being read? Yes No
turn pages of a book and look at pictures? Yes No
recall stories or events? Yes No
enjoy playing alone or with imaginary friends? Yes No
talk with your friends/relatives who come to visit? Yes No
follow simple, age-appropriate directions? Yes No

What are your child's favorite activities?

Does your child have opportunities to play with other children? Yes No

How many hours a day does your child spend watching TV?

Does he or she sit very close to the TV? Yes No

Does he or she turn up the volume very high? Yes No

Are there other things you would like to tell us about your child?