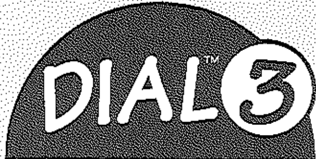

Parent Questionnaire

Carol Mardell-Czudnowski, PhD
Dorothea S. Goldenberg, EdD

Child's Name ______________________________

School ____________________ City ____________________ State ____________

This form was filled out by

☐ Mother ☐ Father ☐ Other (please specify relationship) ____________________

Name of person filling out form ____________________ Date form filled out ____________

To the Parent:

This form has four parts that ask for information about your child:

Part 1. Personal/Medical asks about your child's background.
Part 2. Self-Help Development asks about your child's ability to care for himself or herself.
Part 3. Social Development asks about how your child behaves with other people.
Part 4. Overall Development is a place for you to write any concerns or worries you might have.

A fifth part asks for your input on the screening program. Please read through the form and respond to all items as carefully as you can. You are an important source of information about your child. We very much need the answers and comments only you can provide.

The questions are arranged in the order that skills tend to develop in children. Some of the items, especially the later ones, may cover skills that your child is just not ready for yet. Please do not be concerned. We use the same form with children ages 3 through 6, and we ask about some skills that are difficult even for the oldest children.

Thank you for your help.

PEARSON

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Part 4. Overall Development

Directions: Place an **X** in the column that best describes your level of worry about each area of your child's development. We understand that you are naturally concerned about all of these areas. We would like to know any areas that you think may be problem areas for your child. Think of your child at home. Responses will be used to help us understand your child's growth and needs.

Area of Development	My child is doing OK	I'm a little worried	I'm somewhat worried	I'm very worried
General development				
Health				
Motor skills				
Understanding and thinking skills				
Language skills				
Self-help skills				
Social skills				
Vision				
Hearing				

Please describe any other specific worries you have about your child: ______________________________

____

____

____

Part 5. Evaluation of the Screening Program

Directions: We would appreciate your evaluation of this screening.

1. How did you find out about preschool screening? ______________________________

   ____

2. What information were you given about preschool screening? ______________________________

   ____

3. What did you like about this screening? ______________________________

   ____

4. What did you dislike about this screening?______________________________

   ____

5. Do you feel that preschool screening is worthwhile?______________________________

   ____

6. What changes do you recommend? ______________________________

   ____

Personal/family history (such as divorce, a recent death in the family, etc.): ______________________

____

____

____

____

____

During the day, my child (check all that apply):

- ☐ attends preschool
  - ☐ full day
  - ☐ half day
- ☐ attends family daycare
  - ☐ full day
  - ☐ half day
- ☐ attends kindergarten
  - ☐ full day
  - ☐ half day
- ☐ attends a daycare center
  - ☐ full day
  - ☐ half day
- ☐ is home with a parent
  - ☐ full day
  - ☐ half day
- ☐ is home with a sitter
  - ☐ full day
  - ☐ half day

Part 3. Social Development

Directions: Place an **X** in the box that tells how frequently your child shows each feeling or behavior. Again, think of your child on an average day, at home or with friends. Mark each item by putting an **X** in one of the boxes.

Feeling or Behavior	Always or almost always	Sometimes or partially	Never or almost never
1. Sticks to one activity (listens to a story, does coloring) for at least 15 minutes at a time.			
2. Accepts limits without getting upset.			
3. Plays with toys without breaking them.			
4. Plays well with other children (takes turns, shares).			
5. Stops an activity when parents say to do so.			
6. Keeps working at something until it is finished.			
7. Is well liked by other children.			
8. Does what parents ask him or her to do.			
9. Waits his or her turn in games.			
10. Over-reacts or has temper tantrums.			

Feeling or Behavior	Always or almost always	Sometimes or partially	Never or almost never
11. Uses words rather than physical actions to settle arguments with other children.			
12. Likes to be with other people.			
13. Reacts in ways parents can predict.			
14. Admits mistakes and doesn't blame others.			
15. Is easily frustrated.			
16. Describes others' feelings (such as happy, sad, mad).			
17. Smiles, giggles, or laughs in response to something funny.			
18. Waits to hear the entire question before answering.			
19. Goes to bed easily and without a struggle.			
20. Asks permission to use something that belongs to someone else.			

Social Raw Score (max. = 40) ☐

Part 1. Personal/Medical Information

This part is for you to give information on your child's personal and medical history. Include anything that you think may have been important to your child's development.

Medical/health history of your child (such as premature birth, serious illness, ear tubes, etc.):

____

____

____

____

____

____

Medication is/was given for: ____

____

____

Part 2. Self-Help Development

Directions: Place an X in the box that best describes how your child can do each task. A young child's behavior is not the same from day to day. Think of your child's average ability at home, not his or her very best or worst day. Mark each item by putting an X in one of the boxes.

Example	Most of the time, with no help	Some-times, or if I help	No, not yet	Not allowed to or not asked to
1. Drinks from a straw.		X		
2. Buttons large buttons.	X			

Task	Most of the time, with no help	Some-times, or if I help	No, not yet	Not allowed to or not asked to
1. Drinks from a straw.				
2. Buttons large buttons.				
3. Puts toys away when asked.				
4. Unscrews jar lid or bottle cap.				
5. Washes and dries hands.				
6. Puts clothes or shoes where they belong when asked.				
7. Drinks from a water fountain.				
8. Brushes teeth.				

Task	Most of the time, with no help	Some-times, or if I help	No, not yet	Not allowed to or not asked to
9. Blows and wipes nose without being asked.				
10. Puts on clothes with front and back correct.				
11. Puts shoes on correct feet.				
12. Completely dresses himself or herself.				
13. Uses the toilet.				
14. Brushes or combs hair.				
15. Washes his or her own body during bath or shower.				

Self-Help Raw Score (max. = 30)