FOR Training Purposes

Early Screening Inventory-Revised™ Meisels et al.

Parent Questionnaire

Date _____

CHILD INFORMATION

NAME _____ ☐ Male ☐ Female

HOME ADDRESS Street _____ Apt _____

City _____ State _____ Zip _____

Phone (_____) _____ Date of Birth _____

Who is completing this Parent Questionnaire? ☐ Mother ☐ Father ☐ Other Relative (specify) _____ ☐ Guardian ☐ Caregiver ☐ Other (specify) _____

FAMILY

Mother

NAME _____

HOME ADDRESS Street _____ Apt _____

☐ same as child's City _____ State _____ Zip _____

Phone (_____) _____ Date of Birth _____

EDUCATION Highest Grade Completed _____

OCCUPATION (be specific) _____

Father

NAME _____

HOME ADDRESS Street _____ Apt _____

☐ same as child's City _____ State _____ Zip _____

Phone (_____) _____ Date of Birth _____

EDUCATION Highest Grade Completed _____

OCCUPATION (be specific) _____

Other Family Information

With whom has the child lived for most of the past year? ☐ Mother ☐ Father ☐ Both ☐ Guardian ☐ Other (specify) _____

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 _____

MEDICAL HISTORY

Birth

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

_____

_____

_____

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:

_____

_____

_____

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:

_____

_____

_____

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:

_____

_____

_____

COORDINATION

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

_____

_____

_____

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:

Does your child have allergies? ☐ Yes ☐ No

If yes, please describe:

Is your child presently on any medications? ☐ Yes ☐ No

If yes, please describe:

Please describe any other health concerns:

CHILD'S DEVELOPMENT

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 opportunites 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?

_____

_____

_____

_____

_____

_____

_____