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 Parent Questionnaire? Name _____

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:

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 explain:

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

If yes, please explain:

Please describe any other health concerns: ☐ Yes ☐ No

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:

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?