

# Early Childhood Family Questionnaire

Your responses on this questionnaire will help us to learn more about your child. Please complete each item and return it with your completed application form. There are no “right” or “wrong” answers to the questions.

Child’s Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Is your child adopted \_\_\_\_\_ Is there a parent custodial? \_\_\_\_\_

What languages are spoken in the home? \_\_\_\_\_

## General

Tell us about your experiences with and observations of your child.

1. Describe a typical weekday for your child.

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2. Describe a typical weekend for your child.

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3. What are two things that your child likes to do best?

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4. What are two things your child does not like to do?

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5. What is your favorite thing to do with your child?

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6. What are three words you feel best describe your child?

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7. What do you enjoy most about your child? What makes your child special?

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## Practical Life at Home

Tell us about your child's routines and general skills

1. What is your child's normal bedtime? Where do they usually fall asleep (in their bed, in your bed, in your arms, on the sofa...)?

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2. What time does your child normally wake up in the morning?

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3. Does your child normally take a nap during the day? If so, how long do they normally sleep?

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4. What does your child normally eat for breakfast?

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5. What does your child like to eat most?

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6. Are there any foods that they will not eat?

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7. Does your child feed him or herself?

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8. Does your child dress him or herself?

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9. Does your child use the toilet independently? If not, please tell us where they are in this process.

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10. Please tell us about your approach to discipline? (time-out, spanking, redirecting...)

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## Medical History

1. Were there any significant problems during pregnancy or directly following birth that might have an effect on your child's development (i.e. premature birth, low birth weight, etc.)?

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2. Was your child more than 3 weeks premature?

Yes     No

3. Have you ever suspected that your child has vision problems?

Yes     No

If yes, please explain:

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4. Have you ever suspected that your child has hearing problems?

Yes     No

5. If yes, please explain:

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6. Has your child ever had trouble walking, climbing, reaching, holding on to things

Yes     No

7. If yes, please explain:

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8. Does your child have allergies?

Yes     No

If yes, please explain:

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9. Is your child presently on any medications?

Yes     No

If yes, please explain:

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