

Family Questionnaire



St. MARGARET MARY
SCHOOL COMMUNITY

7813 Shelbyville Road,
Louisville, KY 40222
(502)426-2635 Ext. 0
school@stmm.org

Parent Name _____

Home Phone _____

Cell Phone _____

Email Address _____

Child's Name _____

Birth Date _____

Boy | Girl Nickname _____

Primary Language _____

Parent(s) Name(s) _____

The Pre-school my child attends: _____

Siblings _____ Age _____

_____ Age _____

_____ Age _____

_____ Age _____

Who completed this form? _____

Relationship to child _____ Date _____

1. My child uses:

- | | | |
|--------------------|-----------------|----------------------------|
| _____ Crayons | _____ Pencil | _____ Refrigerator |
| _____ Glue | _____ Blocks | _____ Computer |
| _____ Scissors | _____ Bicycle | _____ Microwave |
| _____ Finger paint | _____ Telephone | _____ Handheld video games |
| _____ TV | | |

2. When school is not in session, my child is:

- _____ At home with a caretaker
_____ At a Daycare Please list Provider _____
_____ Other

3. The things my child does that please me the most are _____

4. The things my child does (or does not do) that concern me the most are_____

5. My child prefers the following toys and activities_____

6. The activities my child and I do together are_____

7. The form of discipline is used for negative/positive behavior_____

1. I give my child medication for_____

2. My child has the following medical problems _____

3. My child is allergic to_____

4. When my child is given a pencil, pen, or crayon, he/she will_____

5. When I leave my child for a short time or with a sitter, he/she will_____

6. When my child and I look at books, he/she will_____

7. When I call my child from an activity, he/she will_____

8. My child:

_____ Generally sleeps through the night in his/her own bed

_____ Frequently sleeps in our room

_____ Frequently wakes up

9. My child sleeps:

_____ Less than most children

_____ More than most children

_____ Average compared to most children

10. My child is:

- Independent
- Dependent for his/her age

11. My child is:

- Right Handed
- Left Handed
- Undecided

Please check the following that apply from the list:

My child:

- | | |
|--|---|
| <input type="checkbox"/> Is able to accept limits | <input type="checkbox"/> Has difficulty using pencils, crayons, or scissors |
| <input type="checkbox"/> Easily smiles, giggles, or laughs | <input type="checkbox"/> Is able to button |
| <input type="checkbox"/> Awakens easily | <input type="checkbox"/> Is able to zip |
| <input type="checkbox"/> Plays with other children | <input type="checkbox"/> Has difficulty with hand/eye coordination |
| <input type="checkbox"/> Separates from me easily | <input type="checkbox"/> Has poor control of body |
| <input type="checkbox"/> Plays well in a group | <input type="checkbox"/> Asks people to repeat or talk louder |
| <input type="checkbox"/> Often takes a nap | <input type="checkbox"/> Favors one ear over the other |
| <input type="checkbox"/> Has unclear or garbled speech | <input type="checkbox"/> Is startled at sudden noises |
| <input type="checkbox"/> Has difficulty expressing wants | <input type="checkbox"/> Has earaches |
| <input type="checkbox"/> Uses complete sentences | <input type="checkbox"/> Speaks loudly |
| <input type="checkbox"/> Needs instructions repeated often | <input type="checkbox"/> Watches a person's face when that person talks |
| <input type="checkbox"/> Helps with household chores | <input type="checkbox"/> Squints |
| <input type="checkbox"/> Takes care of own toileting needs | <input type="checkbox"/> Sits too close to the TV |
| <input type="checkbox"/> Has difficulty dressing him/herself | <input type="checkbox"/> Holds a book very close to his/her face |
| <input type="checkbox"/> Is easily distracted | <input type="checkbox"/> Blinks a lot |
| <input type="checkbox"/> Darts from one task to another | <input type="checkbox"/> Rubs his/her eyes |
| <input type="checkbox"/> Persists when asked to stop | <input type="checkbox"/> Asks for adult help when needed |
| <input type="checkbox"/> Attends to task for a reasonable period of time | |
| <input type="checkbox"/> Seems to understand directions | |
| <input type="checkbox"/> Acts much younger than his/her peers | |
| <input type="checkbox"/> Seeks much younger friends | |

Please share any further information that has not been addressed _____

Has your child ever received any special services?

- Speech articulation
- Speech language development
- Occupational Therapy
- First Steps
- Physical Therapy
- Treatment for medical conditions (eg. Seizures, hearing, vision, neurological)
- Other

Please describe:

Is a written report available? If so, please provide. _____

Has your child ever been assessed OR is in the process of being assessed for any special services or concerns? If so, please describe. _____

I give my permission to personnel at St. Margaret Mary School to contact my child's Pre-school Teacher/ Childcare Provider for further information.

Parent's Signature

Date