SAN RAMON VALLEY UNIFIED SCHOOL DISTRICT
1475 Harlan Drive, Danville, California 94526
PRESCHOOL ASSESSMENT TEAM
Office (925) 855-5360 • FAX (925) 837-8727

PLEASE PRINT CLEARLY AND ANSWER ALL QUESTIONS

CHILD INFORMATION QUESTIONNAIRE

Name of person completing this form: _____

Date: _____

GENERAL INFORMATION

Child's Name: _____ Date of Birth: _____
Gender: male or female

Mother: _____ Father: _____

Child resides with: _____ Ethnicity: _____

Other children in the home: brothers _____ sisters _____

Address: _____ Phone numbers: home _____

_____ cell(s) _____

_____ work _____

Email: _____

** PLEASE CIRCLE PREFERRED METHOD OF COMMUNICATION ABOVE. **

Primary language spoken in the home: _____

Other language(s) spoken to/by the child: _____

Child's primary language: _____

Does your child attend school now, or has s/he attended any programs in the past? Yes or No

If yes, please list names, addresses, phone numbers, and days/hours of attendance:

_____

Is there family history of learning difficulties, developmental delays, or mental illnesses? Yes or No

If yes, please briefly describe: _____

Do you have any children who have or are presently receiving special education services? Yes or No

If yes, please list: _____

HEALTH AND DEVELOPMENTAL HISTORY

My child was ___ full term _____ preterm by ____ weeks

Were there any complications at birth? Y N If so, please briefly explain _____

Was there any prenatal exposure to drugs or alcohol? Y N If so, please list _____

Have there been any injuries or hospitalizations? Y N If so, please list dates and reasons _____

My child is: ____ toilet trained _____ partially toilet trained ____ not yet toilet trained

My child speaks in ☐ single words, ☐ short phrases, ____ sentences, ____ does not use words

Please fill in ages to the best of your recollection: my child

sat up independently _____ crawled _____ walked _____ said first word _____

Please list any medications or supplements your child presently takes_____

Does your child have any known allergies? Y N If yes, please list _____

Current vision test results (**date and findings**): _____

Current hearing test results (**date and findings**): _____

Did your child have frequent ear infections/tubes in ears? Y N If so, about how many and how often or when were tubes place? _____

REASON FOR REFERRAL

Please describe your concerns about your child: _____

_____

_____

_____

When was this problem first noticed? _____

Have you consulted with any other professionals regarding these concerns? _____ yes _____ no
If yes, with whom did you consult and what was the outcome? _____

_____

Tell us some of the best things about your child: _____

_____

_____

_____

What does your child like to do? What does she/he like to play with? _____

_____

How much time does your child spend on a phone/tablet and/or watching TV per day?
☐ less than one hour ☐ 1-2 hours ☐ 2-3 hours ☐ 3-4 hours ☐ 5+ hours

AREAS OF STRENGTH OR CONCERN

Behavior

☐ no concerns in this area _____ generally well-behaved/follows rule _____ hits others

☐ has tantrums ☐ difficulties accepting limits ☐ resists rules/refuses to comply

____ is destructive with toys ____ rarely smiles, laughs, giggles _____ independent

Please explain any areas checked _____

_____

Social/Play Skills

____ no concerns in this area ____ plays well with peers ____ engages in frequent pretend play

____ does not play with other children ____ shows little/no interest in others around him/her

____ clingy/does not separate easily ____ does not engage in group activities

____ does not use toys appropriately ☐ does not regularly seek company of others

____ does not show things to parents or point out things of interest to others

____ trouble sharing _____ prefers active play _____ does not ask others to play with him/her

____ acts younger than other children the same age ____ seeks younger/older friends

____ prefers company of adults to children _____ other (explain below)

Please explain any areas checked _____

_____

Attention/Sensory

____ no concerns in these areas _____ sits well for stories _____ looks at others when spoken to

____ easily distracted ____ has a short attention span ____darts from one thing to another

____ picky eater ____ does not look when name is called _____ sensitive to textures

____ trouble with transitions ____ stares/looks at things such as fans, mirrors ____ poor eye contact

____ is overwhelmed in groups/loud environments _____ does certain things repetitively

_____ bothered by certain sounds _____ jumps, moves around often/has trouble sitting still

Please explain any areas checked _____

_____

Speech/Language

____ no concerns in this area ☐ shares interests with others with words or gestures

____ has unclear speech ____has difficulty expressing wants/needs ____uses incomplete sentences

____ needs instructions repeated often ____doesn't seem to remember information

____ does not answer questions or gives answers that don't make sense ____ does not ask questions

____ makes sounds as if s/he is talking, but they are not real words _____ repeats what others say

Please explain any areas checked _____

_____

Motor/Self-Help

_____ no concerns _____dresses self _____ feeds self with a spoon/fork _____ buttons clothing

_____ clumsy/poor coordination ____ trouble with writing/drawing ____drinks only from sippy cup

Please explain any areas checked _____