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Parent Questionnaire for Kindergarten Children

Dear Parents!

Thank you for taking the time to complete this comprehensive questionnaire. The detailed information you provide will help me better understand your child's unique strengths and needs, allowing us to create the most effective therapeutic approach together.

Please complete each section as thoroughly as possible. If you're unsure about any question or need clarification, please don't hesitate to contact me by phone.

Your insights as parents are invaluable in supporting your child's development.

Personal Details

First Name	Last Name	ID Number	Date of Birth	Age (years and months)

Country of Birth	Address	Phone numbers
	Father's	Father's
Migration date	Mother's	Mother's

Emails	Educational Framework	Health services
Father's		
Mother's		

Languages spoken at home_____

Referring party and reason for referral: _____

_____

_____

_____

_____

_____

_____

1. **Family Members**

Father's Name: _____ Occupation: _____

Mother's Name: _____ Occupation: _____

Parental Marital Status: Married / Divorced / Separated / Remarried / Single Parent /Other_____

_____

Children in the family

Name	Age	Medical follow-up/Therapy, in the past/present

Describe the quality of the child's relationship with the father: _____

_____

_____

Describe the quality of the child's relationship with the mother: _____

_____

_____

Describe the quality of the child's relationship with the siblings: _____

_____

2. Additional Professional and/or Therapeutic Providers

Treating Professional	Therapeutic Framework				Frequency of Treatment	Duration of Treatment
Psychologist	Kindergarten	Community Center	Health Fund	Private		
Medical Professional (Developmental Pediatrician, Neurologist, Psychiatrist)						
Social Worker						
Physiotherapist						
Occupational Therapist						
Speech-Language Pathologist						
Inclusion Kindergarten Teacher						
Behavioural therapist						
Others						

4. Medical History

Was the pregnancy normal? Yes / No Details: _____

_____

Duration of pregnancy: _____

Delivery method: Normal / Forceps / Vacuum / Cesarean: _____

Were there any complications after birth? _____

_____

Newborn weight: _____

Does your child take medication regularly? Yes / No
If yes, which? _____

Is there any known drug allergy? _____

Is there any known allergy? _____

Are there any difficulties / illnesses / syndromes / learning disabilities in the family?
_____

_____

Has the child been hospitalized or undergone surgery? _____

_____

3. Developmental Background

Did your child reach developmental milestones on time? Yes / No: _____

_____

Please write the age. If you do not remember the exact age, indicate whether it was early /on time /late:

Rolling over: _____ Crawling: _____

Standing: _____ Walking: _____

Sitting: _____ Toilet training: _____

4. Sensory Development

Is there sensitivity or lack of sensitivity to noise / touch / tastes / materials/Smells/ Seeking Movement, or Avoidance of Movement: _____

_____

5. Eating

Breastfeeding: Yes / No. If not, why? _____

At what age did your child transition to pureed foods? _____

At what age did your child transition to solid foods? _____

Were there any difficulties during the transitions? _____

_____

Were there any eating difficulties? _____

Are there currently any difficulties with eating? _____
_____

Does your child vomit frequently? _____

Is your child willing to try new foods? _____

Does your child eat in a clean and orderly manner (making a mess of self and surroundings)? _____

Is your child independence in eating (including use of knife and fork)_____

_____

Circle the answer that applies to your child:
Soft foods: Likes / Avoids Details:_____

Hard foods: Likes / Avoids Details: _____

Mix texture (as soup, yogurt with fruits): Likes / Avoids Details: _____

_____

Does your child use a pacifier: Yes / No
Has the child been weaned off the pacifier? Yes / No
If yes, at what age? _____

6. <u>Language and Communication</u>

Did the child establish eye contact naturally? Yes/No_____

Did the child learn to make eye contact? Yes/No _____

Does your child direct a smile toward others? Yes/No_____

During infancy, did your child go through a period of babbling (repeating syllables such as “bababa”)? Yes/No When? _____

When did your child say their first words (words with consistent meaning, even if not pronounced correctly)? _____

When did your child begin to combine two words? _____

When did your child begin to speak in sentences? _____

Is the child able to form sentences in sequence? _____

_____

How would you describe your child's vocabulary size? (Small / Medium / Large) ___

_____

Is your child able to express them self verbally (when asking for something, when telling about an experience)?_____

_____

Does your child substitute words or have difficulty finding certain words? _____

_____

Is your child's speech understood by adults / peers? _____

_____

Is there frustration due to speech/language/communication difficulties? Yes/No
If yes, how does the frustration manifest? _____

_____

How many hours a day does the child spend on a screen? _____

What exactly does he/she do? _____

_____

7. Hearing

Has the child had a hearing test? Yes/No_____

What were the results? _____

Has the child suffered from recurrent ear infections? Yes/No

When was the last hearing test performed? _____

What were the results? _____

8. Play

What does your child play with? _____

_____

Does the child play interactive games? Yes/No Examples: _____

_____

Imaginative play? Yes/No Examples: _____

_____

9. Independence in ADL (Activities of Daily Living)

Is your child independent in bathing? Yes/No _____

Is your child independent In personal hygiene? Yes/No _____

Is your child independent in dressing? Yes/No _____

Is your child independence with buttons? Yes/No _____

Is your child independence with shoelaces? Yes/No _____

10. Sleep

What time does your child go to bed (is it at a regular time)? _____

_____

When does your child fall asleep? _____

Is your child calm / restless during sleep? _____

_____

Does your child wake up at night? Yes/No If yes, why? _____

_____

11. Emotional and Behavioral Regulation

How well does your child delay gratification? _____

_____

How well does your child cope with difficulties? _____

_____

How does your child react to new people / situations? _____

_____

How does your child react to transitions between activities? _____

_____

How would you describe your child's general mood? _____

Are there any unusual behaviors (tantrums, bedwetting, repetitive movements)? _____

_____

_____

12. Social Skills

Does your child enjoy playing with peers, or prefer to play alone or with adults? ____

_____

_____

Does your child engage in free play independently? _____

_____

Does your child initiate play with other children? Yes / No_____

_____

Does your child respond positively when approached by peers? Yes / No_____

_____

Does your child participate in extracurricular activities? Yes/No If yes – which ones?
_____

Can your child share toys or materials with others? Always / Sometimes / Rarely / Never_____

Can your child take turns during games or activities? Always / Sometimes / Rarely / Never_____

How does your child handle disagreements with peers? _____

_____

Does your child follow group rules or instructions in class/play settings? Always / Sometimes / Rarely / Never_____

Can your child wait for their turn in group activities? Always / Sometimes / Rarely / Never_____

Does your child have close friends at school or in the neighborhood? _____

_____

Can your child express emotions appropriately in social situations? Always / Sometimes / Rarely / Never_____

_____

Does your child notice when others are happy, sad, or upset? Always / Sometimes / Rarely / Never_____

_____

What are your child's main social strengths? _____

_____

Are there any social difficulties you have noticed? _____

_____

13. Gross Motor / Physical Activity in Space

	Avoids Activity	Usually Struggles	Sometimes Succeeds	Succeeds and Enjoys
Running				
Jumping				
Using playground equipment				
Ball games				
Group activities with peers				
Sitting on a chair for an extended period during activities				

14. Fine Motor Skills and Creativity

	Avoids Activity	Usually Struggles	Sometimes Succeeds	Succeeds and Enjoys
Playing with small objects (LEGO, beads, blocks)				
Free drawing				
Exploring different craft materials				
Cutting				
Using writing tools (pencils, markers, crayons)				

15. General

What are your child's areas of strength? _____

_____

Does your child have any difficulties not mentioned in this questionnaire so far?
Yes/No If yes, what are they? _____

_____

Your personal impression of your child's functioning in kindergarten / school, including difficulties and strengths
(e.g., independence in organizing and completing tasks, transitioning between activities, attention and concentration, learning abilities):_____

_____

_____

Comments: _____

_____

_____

Name of person completing the questionnaire: _____

Date: _____