Marblehead Public Schools
Integrated Preschool Screening Caregiver Questionnaire

This form has several parts: personal background information about your child, health information, self-help development about your child's ability to care for him/herself, and social development. Please read through the form and respond to all the questions. You are an important source of information about your child and the information and answers that you provide enable us to better understand them.

PERSONAL INFORMATION

Who is completing the questionnaire? _____

Child's Information

Name_____ DOB: _____ Gender: _____

Address: _____

What language does your child speak at home? _____

What languages are spoken at home? _____

Family Information

Caregiver/Guardian 1: _____ Age:_____

Phone: _____ Email Address: _____

Occupation: _____ Highest Level Education: _____

Caregiver 2: _____Age:_____

Phone: _____ Email Address: _____

Occupation: _____ Highest Level Education: _____

Caregiver/guardians are: ☐ single ☐ married ☐ divorced ☐ separated ☐ idowed

With whom has the child lived with for most of the past year? _____

Please list all the family members/others currently in the home:

Name/Age	Relationship	Currently in home? Y/N	Grade/Occupation

Has your child attended preschool/daycare? If yes, where, since what age, and how many hours per week?

_____

HEALTH INFORMATION

Was the pregnancy full term and normal? Yes ☐ No ☐

Was the labor and delivery normal? Yes ☐ No ☐ if no, please explain: _____

_____

Birth weight: _____

If premature, how many weeks early? _____

Does your child have vision difficulties? Yes ☐ No ☐ Please explain

_____

Does your child have frequent ear infections? Yes ☐ No ☐ Please explain

_____

Does your child have ear tubes? Yes ☐ No ☐ At what age: _____

Has your child had a tonsillectomy or adenoidectomy? Yes ☐ No ☐ At what age? _____

Does your child have a significant medical history due to an accident, illness, or medical condition?

Yes ☐ No ☐ please explain: _____

_____

Has your child ever been hospitalized overnight ? Yes ☐ No ☐ Please explain

_____

Does your child have allergies? Yes ☐ No ☐ Please explain

_____

Is your child currently on any medications? Yes ☐ No ☐ Please explain

_____

Please describe any other health concerns: _____

SPEECH AND LANGUAGE

	Yes	No
Difficulty saying sounds clearly/ unintelligible speech	☐	☐
Stuttering/stammering difficulties	☐	☐
Difficulty reasoning or problem solving	☐	☐
Follows 2-step requests that are sequential, but not necessarily related	☐	☐
Engages in conversations (tells about past event, asks how something works)	☐	☐
Participates in songs, rhymes, games, and stories that play with sounds of language	☐	☐
Makes requests	☐	☐
He/she is generally understood by people outside of the family	☐	☐
I have to restate what my child has said to others	☐	☐

SENSORY

	Yes	No
Fearful of loud noises	☐	☐
Does not like crowds	☐	☐
Is a picky eater (does not like certain foods, textures, colors)	☐	☐
Certain clothing (tags, socks, different materials) bothers child	☐	☐
Overwhelmed in new situations	☐	☐

MOTOR SKILLS

	Yes	No
Throw or catch a ball	☐	☐
Hop on one foot	☐	☐
Jump forward with both feet together	☐	☐
Go upstairs w/alternating feet	☐	☐
Go downstairs with alternating feet	☐	☐
Balance on one foot for three to five seconds	☐	☐
Pedal a tricycle	☐	☐
Skips or gallops	☐	☐
Hold a crayon and draw/color with it	☐	☐
Can string beads	☐	☐
Can snip with scissors	☐	☐
Can copy a horizontal line, vertical line and a circle	☐	☐
Can fasten buttons	☐	☐

SELF HELP SKILLS

	Yes	No
Put away toys	☐	☐
Clean up a spill	☐	☐
Put shoes on correct foot	☐	☐
Wash/dry hands	☐	☐
Hang a coat	☐	☐
Follow 2-step directions	☐	☐
Blow or wipe nose when prompted	☐	☐
Brush teeth	☐	☐
Completely get dressed	☐	☐
If toilet trained, take care of all toileting needs	☐	☐

	YES	NO
Ask an adult for help, when needed		
Drink from an open cup (not sippy)		
Drink from a straw		
Feed self, using spoon or fork		
Goes to bed without difficulty		
Stays in own bed all night		
Can say first and last name when asked		

SOCIAL DEVELOPMENT INFORMATION

	Yes	No
Gives eye contact to the person speaking		
Sticks to one activity for at least five minutes, not including the TV or computer		
Initiates play with other children		
Has opportunity to play with age appropriate peers		
Separates easily from parents		
Demonstrates appropriate imaginary play skills		
Cooperated with peers during play		
Negotiates with peers to resolve conflicts		
	Yes	No
Responds to and makes verbal greetings at appropriate times		
Follows rules when participating in routine activities		
Defiance/non-compliant		
Excessive or long lasting tantrums		
Aggressive behavior toward self or others		
Fearful or anxious		
Is on the go or often acts as if he/she is “driven by a motor”		

Are there challenges with behavior management at home? Yes ☐ No ☐ Please explain

_____

What are your child’s favorite activities?

_____

What are your child’s strengths?

_____

When your child is upset, how are they soothed?

_____

How many hours a day does your child watch television or spend in front of a screen?

_____

Please provide information regarding any previously completed assessments or evaluations in the following areas:

Cognitive: _____

Neurological: _____

Speech/Language: _____

Occupational Therapy: _____

Physical Therapy: _____

Developmental: _____

Early Intervention: _____

Is there any additional information you would like to share?

M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer no. Please circle yes or no for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (For Example, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes No
2. Have you ever wondered if your child might be deaf?	Yes No
3. Does your child play pretend or make-believe? (For Example, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes No
4. Does your child like climbing on things? (For Example, furniture, playground equipment, or stairs)	Yes No
5. Does your child make unusual finger movements near his or her eyes? (For Example, does your child wiggle his or her fingers close to his or her eyes?)	Yes No
6. Does your child point with one finger to ask for something or to get help? (For Example, pointing to a snack or toy that is out of reach)	Yes No
7. Does your child point with one finger to show you something interesting? (For Example, pointing to an airplane in the sky or a big truck in the road)	Yes No
8. Is your child interested in other children? (For Example, does your child watch other children, smile at them, or go to them?)	Yes No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (For Example, showing you a flower, a stuffed animal, or a toy truck)	Yes No
10. Does your child respond when you call his or her name? (For Example, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes No
11. When you smile at your child, does he or she smile back at you?	Yes No
12. Does your child get upset by everyday noises? (For Example, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes No
13. Does your child walk?	Yes No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes No
15. Does your child try to copy what you do? (For Example, wave bye-bye, clap, or make a funny noise when you do)	Yes No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes No
17. Does your child try to get you to watch him or her? (For Example, does your child look at you for praise, or say “look” or “watch me”?)	Yes No
18. Does your child understand when you tell him or her to do something? (For Example, if you don’t point, can your child understand “put the book on the chair” or “bring me the blanket”?)	Yes No

19. If something new happens, does your child look at your face to see how you feel about it? (For Example, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?) Yes ◯ No ◯

20. Does your child like movement activities? (For Example, being swung or bounced on your knee) Yes ◯ No ◯