



# Early Screening Inventory-Revised™ Meisels et al.

## Parent Questionnaire

Date \_\_\_\_\_

### CHILD INFORMATION

NAME \_\_\_\_\_  Male  Female

HOME ADDRESS Street \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Who is completing this Parent Questionnaire?  Mother  Father  Other Relative (specify) \_\_\_\_\_  
 Guardian  Caregiver  Other (specify) \_\_\_\_\_

### FAMILY

#### Mother

NAME \_\_\_\_\_

HOME ADDRESS Street \_\_\_\_\_ Apt \_\_\_\_\_

same as child's City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_

EDUCATION Highest Grade Completed \_\_\_\_\_

OCCUPATION (be specific) \_\_\_\_\_

#### Father

NAME \_\_\_\_\_

HOME ADDRESS Street \_\_\_\_\_ Apt \_\_\_\_\_

same as child's City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_

EDUCATION Highest Grade Completed \_\_\_\_\_

OCCUPATION (be specific) \_\_\_\_\_

#### Other Family Information

With whom has the child lived for most of the past year?  Mother  Father  Both  Guardian  
 Other (specify) \_\_\_\_\_

Other children in the family – How many older? \_\_\_\_\_ How many younger? \_\_\_\_\_

Other people living in the household \_\_\_\_\_

What language(s) are spoken at home?  English  Other (specify) \_\_\_\_\_

### PRESCHOOL/CHILD CARE HISTORY

Has your child attended preschool/child care before?  Yes  No

If yes, for how long?  6 months  1 year  2 years  more than 2 years

Name of child's present or most recent school \_\_\_\_\_

## MEDICAL HISTORY

### Birth

Were there any significant problems during pregnancy?  Yes  No

If yes, please explain:

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Was your child more than 3 weeks premature?  Yes  No

If yes, how many weeks premature? \_\_\_\_\_

Baby's birth weight \_\_\_\_\_

Did the baby stay in the hospital longer than the mother?  Yes  No

If yes, please explain:

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At the time of birth, did the baby — have seizures  Yes  No  
turn blue?  Yes  No

### Child's Health Since Birth

**EYES** Has your child ever had trouble seeing?  Yes  No

Does your child hold books and objects close to his or her face?  Yes  No

Have your child's eyes ever looked crossed?  Yes  No

Have you ever suspected that your child has vision problems?  Yes  No

If yes, please explain:

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**EARS** Has your child had frequent ear infections?  Yes  No

Has your child ever had trouble hearing?  Yes  No

Have you ever suspected that your child has hearing problems?  Yes  No

If yes, please explain:

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**COORDINATION** Has your child ever had trouble walking, climbing, reaching,  Yes  No  
holding on to things?

If yes, please explain:

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**MEDICAL HISTORY** (continued)

**Child' Health**

**Since Birth** continued

Has your child ever had any significant injuries or hospitalizations?

Yes  No

If yes, please explain:

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Does your child have allergies?

Yes  No

If yes, please explain:

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Is your child presently on any medications?

Yes  No

If yes, please explain:

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Please describe any other health concerns:

Yes  No

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**SOCIAL, EMOTIONAL, AND SELF-HELP SKILLS**

Can your child — feed him or herself using a spoon and/or a fork?  Yes  No

wash and dry his or her own hands?  Yes  No

help with dressing or dress with little assistance?  Yes  No

stay with a babysitter?  Yes  No

speak so that he or she can be understood by others?  Yes  No

express his or her thoughts and needs easily?  Yes  No

Do you have any concerns about your child's appetite or willingness to try different foods?  Yes  No

If yes, please explain:

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Do you have any concerns about your child's sleeping patterns (going to bed with difficulty or waking often during the night)?  Yes  No

If yes, please explain:

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Is your child — highly active?  Yes  No

very quiet?  Yes  No

Is your child — toilet trained during the day?  Yes  No

in need of help with toileting?  Yes  No

Does your child — play with blocks, boxes, cups, or other construction toys without help?  Yes  No

use crayons and/or markers to scribble or draw?  Yes  No

listen to stories being read?  Yes  No

turn pages of a book and look at pictures?  Yes  No

recall stories or events?  Yes  No

enjoy playing alone or with imaginary friends?  Yes  No

talk with your friends/relatives who come to visit?  Yes  No

follow simple, age-appropriate directions?  Yes  No

What are your child's favorite activities?

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Does your child have opportunities to play with other children?  Yes  No

How many hours a day does your child spend watching TV? \_\_\_\_\_

Does he or she sit very close to the TV?  Yes  No

Does he or she turn up the volume very high?  Yes  No

Are there other things you would like to tell us about your child?

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