6 Danforth Drive
Easton, PA 18045-7899

Colonial Intermediate Unit 20

EARLY INTERVENTION PARENT QUESTIONNAIRE

Child's Name: _____ **Sex:** _____ **Case No:** _____

Completed by: _____ **Date:** _____ **SAE:** _____ **(School Age Eligible)**

School District: _____

DOB: _____ **Age:** _____ Years _____ Mos. **Home School:** _____

Parents: _____ **Telephone # :** ( ) _____ **(Home)**

( ) _____ **(Work)**

( ) _____ **(Cell)**

Address : _____ **Soc. Sec. # :** _____

_____ **Medical Assistance #: Issue # :** _____

E-mail address: _____ **Private Insurance: Yes or No**

REASON FOR REFERRAL:

What are your main concerns about your child: _____

_____

_____

Does your child attend a preschool program, nursery school, or day care:

If so, Name: _____ Hours: _____

Address: _____ Teacher: _____

_____ Telephone Number: (_____) _____

How *is* your child doing in nursery school? _____

_____

Has your child received early intervention services in the past? Describe: _____

_____

Does your child receive any private therapies? Please list: _____

_____

Other agency involvement: (i.e., WIC, C & Y, Provider 50, subsidized day care, etc.) _____

BIRTH HISTORY:

Length of Pregnancy: _____ Mother's age at birth of child: _____

Describe pregnancy complications: _____

_____

List use of medications, drugs, alcohol or cigarettes: _____

_____

Child's Name/#_____

BIRTH HISTORY (continued):

Birth Weight:_____lbs. _____ozs. Length:_____ Duration of Labor:_____

Delivery: ☐ Vaginal ☐Caesarean ☐Anesthesia Used

Any complications? (baby's position, forceps, breathing difficulties, etc.):_____

_____

_____

Length of hospital stay: Mother _____ Child_____

Any complications after birth?_____

_____

_____

DEVELOPMENTAL HISTORY:

Describe any problems during infancy (difficulties with sucking, swallowing, eating solid foods, sleeping, irritability, etc.):

_____

_____

Note approximate age at which your child accomplished the following:

Held head up_____ Crawled_____ Toilet trained: bladder_____bowel_____

Rolled over_____ Stood alone_____ First words (besides mama/dada)_____

Sat without support_____ Walked alone_____ Put words together (give examples)_____

_____

MEDICAL HISTORY:

What specific diagnoses, if any, have been made by a physician?_____

List contagious diseases:_____

Describe any hospitalizations:

Reason	Age	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child had the following:

☐Seizures ☐Ear Infections ☐High Fevers ☐Asthma

☐ Allergies (list):_____

Child's Name/#_____

MEDICAL HISTORY (continued):

Hearing Screened: Where_____ When_____Results_____

Screening Instrument: _____ By Whom: _____

Vision Screened: Where_____ When_____Results_____

Screening Instrument: _____ By Whom: _____

Date of Most Recent Health Appraisal: _____ By Whom: _____

Are immunizations up to date for your child? _____

List any medications your child is currently taking:

Name/Dosage:_____Name/Dosage:_____

Name/Dosage:_____Name/Dosage:_____

Pediatrician:_____

Other medical professionals involved with your child:

Name	Profession	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL/BEHAVIOR:

Please check any of the following that apply to your child:

- ☐ Bedwetting
- ☐ Temper tantrums
- ☐ Bites self/objects/others
- ☐ Head banging
- ☐ Hurts self on purpose
- ☐ Sleeping problems
- ☐ Eating problems
- ☐ Unreasonable fears/worries
- ☐ Tics/nervous habits
- ☐ Short attention span
- ☐ Separation difficulties (from parents)
- ☐ Unusual physical movement/hand flapping
- ☐ Preoccupation with certain objects
- ☐ Trouble getting along with others
- ☐ Difficulty with changes (activities/people)

SENSORY/MOTOR:

Touch:

- ☐ Objects to being touched/cuddled
- ☐ Fearful of having face/hands washed
- ☐ Gets upset/aggressive if others are physically too close
- ☐ Dislikes being barefoot
- ☐ Does not respond to pain

Hearing:

- ☐ Seems overly sensitive to sound
- ☐ Unable to hear whispers
- ☐ Speaks loudly
- ☐ Ignores sounds/certain noises

Vision:

- ☐ Overly sensitive to bright light/sunlight
- ☐ Does not follow moving objects
- ☐ Does not search for removed/hidden object
- ☐ Squints eyes to see objects
- ☐ Unusual tilt of head to look at things
- ☐ Staring spells

Movement/Coordination:

- ☐ Excessive rocking of body
- ☐ Jumps uncontrollably
- ☐ Seeks excessive rough/tumble play
- ☐ Likes fast moving/spinning activities
- ☐ Is hesitant at stairs/curbs
- ☐ Bumps into things/accident-prone
- ☐ Fearful when feet are off ground
- ☐ Toe walking

Taste/Smell:

- ☐ Mouths objects
- ☐ Avoids certain textures of food
- ☐ Smells objects inappropriately
- ☐ Overly sensitive to smell
- ☐ Drools
- ☐ Difficulty chewing/swallowing
- ☐ Eats only soft foods
- ☐ Can't blow soap bubbles
- ☐ Can't use a straw

Child's Name/#_____

1) Describe the child's and family's typical day, for example, care giving routines (playtime and favorite activities) as well as community activities (child care and preschool settings and activities, library, playground, etc.).

2) Are there activities that are challenging for the child and family? This could be either at home, in childcare/preschool settings or during community activities.

3) What are the family's views of their child's strengths and does the family have concerns about the child's development? Do the child's other caregivers or teachers have any concerns?

4) What are the family's resources and strengths, including extended family, friends, community groups, resources, etc?

5) If there are concerns, what does the family want to address first?

6) In addition to the needs for your child, is there any additional information we can provide (i.e., information on nursery schools/daycares, doctors/specialists,child growth/development, behavior)?

Child's Name/#_____

FAMILY HISTORY:

	Mother	Father
Name/Age		
Employed/Type of Work		
Where		
Telephone Number		
Hours		
Grade Completed		
Adjustment To School		
Current Health/Emotional Adjustment		

Are both mother and father living in the home?_____

Primary language spoken in the home_____Second language_____

Are there any cultural considerations (diet, religion, etc)?_____

Siblings:

Name	Birthdate/Age	Name	Birthdate/Age

Do all the siblings live in your home?_____

Other persons in home:

Name	Relationship To Child	Name	Relationship to Child

Additional comments/concerns traumatic experiences/separation from family:_____

The Colonial Intermediate Unit 20 recognizes the need to protect the confidentiality of personally identifiable information in the educational records of exceptional children. This policy has been prepared to insure the privacy rights of parents and exceptional children in the collection, maintenance, release, and destruction of records. This policy incorporates provisions from the Regulations of the State Board of Education On Pupil Records, Commonwealth of Pennsylvania Chapter 15, Department of Education Chapter 342, Special Education Services and Programs 342.68, Family Education and Privacy Act (the "Buckley Amendment") as condified in 20USC 1232g. A copy of the Education Records Policy is available in the central office of CIU 20 which is located at 6 Danforth Drive, Easton, Pennsylvania, 18045-7899.