

**Westwood Public Schools  
Integrated Preschool**

Please complete and return to:  
Westwood Integrated Preschool  
200 Nahatan Street  
Westwood, MA 02090  
781-326-7500 x5113  
781-461-9782 (fax)

**Please fill out this entire form.  
It is very valuable information  
for your classroom teachers.**

**Preschool Developmental Questionnaire**

**Child's Information:**

Child's Name: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_

**Parent/Guardian Information:**

Parent/Guardian Name: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_ Legal Guardian: Yes / No \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_ Legal Guardian: Yes / No \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_

Name of Person Completing Questionnaire: \_\_\_\_\_

Date: \_\_\_\_\_

### Developmental History

This child is number \_\_\_\_\_ out of a total of \_\_\_\_\_ children in your family.

Children:

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Others living in the home (other than your own children):

\_\_\_\_\_

Marital Status:

Married                       Separated                       Widowed  
 Divorced                       Other: \_\_\_\_\_

How many times have you moved since the birth of this child? \_\_\_\_\_

Which language did this child first speak? \_\_\_\_\_

Which language does he/she speak at home? \_\_\_\_\_

Which language does he/she speak with peers? \_\_\_\_\_

Which language does he/she speak with adults? \_\_\_\_\_

Which, if any, family members have experienced difficulty with:

Speech \_\_\_\_\_ Reading \_\_\_\_\_

Math \_\_\_\_\_ Spelling \_\_\_\_\_

### Birth History

Mother's health during pregnancy: \_\_\_\_\_ Length of Pregnancy: \_\_\_\_\_

Any illnesses or complications during pregnancy? Explain: \_\_\_\_\_

\_\_\_\_\_

List any prescribed medication: \_\_\_\_\_

Smoking/drug/alcohol use by mother or father? \_\_\_\_\_

\_\_\_\_\_ Full Term \_\_\_\_\_ Premature

\_\_\_\_\_ Natural \_\_\_\_\_ Caesarean \_\_\_\_\_ Breech \_\_\_\_\_ Fetal Distress \_\_\_\_\_ Forceps

Labor: Hours \_\_\_\_\_ Medications used, if any: \_\_\_\_\_

Birth weight: \_\_\_\_\_ lbs, \_\_\_\_\_ ozs. Any complications? \_\_\_\_\_

Child's condition at birth: \_\_\_\_\_

\_\_\_\_\_ Jaundiced \_\_\_\_\_ Oxygen needed \_\_\_\_\_ Transfusions \_\_\_\_\_ Incubator

Length of hospital stay: Infant \_\_\_\_\_ Mother \_\_\_\_\_

### Early Development

Please record below the age at which your child accomplished the following:

Sat alone	_____	2 or 3 sentences	_____
Crawled	_____	Fed self completely	_____
Began to walk	_____	Toilet Trained	_____
First Words	_____	Rode Tricycle	_____
Any difficulty?	_____		
_____			
_____			

What are your concerns that led to this evaluation?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child had any particular or unusual developmental problems?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Present Development

*Please check areas that apply to your child and comment.*

- Pays attention to reading of a short story \_\_\_\_\_
- Answers simple questions or talks about the story \_\_\_\_\_
- Converses easily with family and friends \_\_\_\_\_
- Baby talk \_\_\_\_\_
- Lisps \_\_\_\_\_
- Speaks in generally clear speech \_\_\_\_\_
- Hesitates or frequently repeats \_\_\_\_\_
- Those unfamiliar with your child can understand his/her speech \_\_\_\_\_

Describe any speech or language problem you think your child might have:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Please check areas that apply to your child and comment.*

- Responds quickly to your voice from a short distance \_\_\_\_\_
- Has trouble listening, attending or hearing \_\_\_\_\_
- Has many friends \_\_\_\_\_
- Prefers to play alone \_\_\_\_\_
- Joins group activities \_\_\_\_\_
- Cries easily \_\_\_\_\_
- Sucks thumb \_\_\_\_\_
- Bites nails \_\_\_\_\_
- Clings to parent in new situations \_\_\_\_\_
- Sticks to task once started \_\_\_\_\_
- Shows motivation to try something new \_\_\_\_\_
- Prefers to be with adults \_\_\_\_\_
- Shares easily \_\_\_\_\_
- Has nightmares \_\_\_\_\_
- Has temper tantrums \_\_\_\_\_
- Daydreams \_\_\_\_\_
- Exhibits moody behavior \_\_\_\_\_
- Sleep behavior \_\_\_\_\_

Do you have any particular management difficulties with your child? Please describe.

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*Please check areas that apply to your child and comment.*

- Draws and colors beyond a simple scribble \_\_\_\_\_
- Stacks blocks \_\_\_\_\_
- Completes simple puzzles \_\_\_\_\_
- Fastens buttons he/she can see \_\_\_\_\_
- Dresses self \_\_\_\_\_
- Hops \_\_\_\_\_
- Alternates feet walking downstairs \_\_\_\_\_
- Uses scissors for rough cutting \_\_\_\_\_
- Throws and catches a ball \_\_\_\_\_

With which hand does your child eat? \_\_\_\_\_

If unsure of your child's handedness, explain why. \_\_\_\_\_

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Describe your child's movement pattern (e.g. awkward, clumsy, agile, quick, slow, hesitant, sure, on the go, quiet). \_\_\_\_\_

Does your child enjoy coloring or table work activities? \_\_\_\_\_

Can your child:

- Take care of his toilet needs by self \_\_\_\_\_
- Be away from parent for 2 to 3 hours contentedly \_\_\_\_\_
- Express feelings \_\_\_\_\_
- Takes care of personal needs (e.g. dressing, clean up) \_\_\_\_\_

### Health

- Tires easily \_\_\_\_\_
- Requires little sleep \_\_\_\_\_
- Quiet, limited energy \_\_\_\_\_
- Frequent colds \_\_\_\_\_
- Ear infections \_\_\_\_\_
- Bedwetting \_\_\_\_\_
- Soiling \_\_\_\_\_
- Allergies \_\_\_\_\_
- Extremely active \_\_\_\_\_
- Headaches \_\_\_\_\_
- Eating Habits \_\_\_\_\_
- Current Medication:  
which? \_\_\_\_\_

For what reason \_\_\_\_\_

- Hospitalization: Age \_\_\_\_\_ Length of stay \_\_\_\_\_  
\_\_\_\_\_

For what reason \_\_\_\_\_

- Illnesses: Age \_\_\_\_\_ Comment \_\_\_\_\_

- Accidents: Age \_\_\_\_\_ Comment \_\_\_\_\_

Convulsions or seizures: Age \_\_\_\_\_ Comment \_\_\_\_\_

- Physical problems (hearing, vision, other) \_\_\_\_\_

Wears glasses:  Yes  No, Comment \_\_\_\_\_

Child's Physician: Name \_\_\_\_\_

Address \_\_\_\_\_

Has your child had any special examinations other than routine physicals? (If so, state reason, type, Name of examiner and location of examination.)

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Has your child ever had a visual examination?  Yes  No

If Yes, Name of examiner \_\_\_\_\_

Date of exam \_\_\_\_\_

Results of exam \_\_\_\_\_

Please check areas that apply to your child and comment: *My child has...*

no special health concerns.

a known medical condition: \_\_\_\_\_

any diagnosed conditions: \_\_\_\_\_

asthma and/or allergies to: \_\_\_\_\_

other special health needs: \_\_\_\_\_

#### Previous School Experience

Has your child had previous school experience?  Yes  No

If yes, Name of School \_\_\_\_\_

Address \_\_\_\_\_

Dates \_\_\_\_\_

What are your child's feelings about entering preschool? Please comment.

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Describe any special interest, talents or intense dislikes characteristic of your child at this stage.

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Additional information about your child that you believe would aid in his/her adjustment:

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Signature

Date

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Printed Name

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Daytime Phone Number