



ASD Early Intervention Services  
5530 E. Northern Lights, Anchorage, AK 99504  
Phone: 742-2657 Fax: 742-2660  
<https://www.asdk12.org/preschool/earlyintervention>

### PARENT/CAREGIVER QUESTIONNAIRE

Full Legal Name of Child: \_\_\_\_\_ Birth Date: \_\_\_\_\_  M  F

Who has legal custody of this child? \_\_\_\_\_ Name of caseworker (if in OCS custody): \_\_\_\_\_

Are there any court orders in effect for your child? (Custody, protective, etc.)?  Yes  No

If yes, please be prepared to provide a copy to the EISC Assessment Team prior to your first appointment.

Names and ages of other children living in the home: \_\_\_\_\_

#### **Parent One Information**

Full Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Residence Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Lives with Child?  Yes  No

#### **Parent Two Information**

Full Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Residence Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Lives with Child?  Yes  No

What language is spoken to your child most often? \_\_\_\_\_ By whom? \_\_\_\_\_

What other languages are spoken in the home? \_\_\_\_\_ By whom? \_\_\_\_\_

Race/Ethnicity of this child (Check all that apply):

White  Black  Hispanic  Asian  American Indian  Alaska Native  Native Hawaiian  Pacific Islander

Name and Address of Childcare/Preschool \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

What are your main concerns regarding your child? \_\_\_\_\_

Please provide information below about any services your child has received:

Type of Therapy/Services	Dates	Name of Therapist/Teacher

### ***Information about Development and Learning***

**Gross Motor:** Large muscle movements such as moving, walking and running

Please check the boxes if your child can do this **most of the time**.

- |  |   |
|--|---|
| <input type="checkbox"/> Walks independently       | <input type="checkbox"/> Uses playground equipment  |
| <input type="checkbox"/> Walks up and down stairs  | <input type="checkbox"/> Shows awareness of safety/danger (If not, please explain): _____ |
| <input type="checkbox"/> Throws an object overhand | _____   |
| <input type="checkbox"/> Runs without falling      | _____   |
| <input type="checkbox"/> Jumps in place            | _____   |

***What should we know about your child's gross motor skills?***

**Fine Motor:** Using hands for activities

Please check the boxes if your child can do this **most of the time**.

- |  |   |
|--|---|
| <input type="checkbox"/> Drops objects into containers   | <input type="checkbox"/> Scribbles with crayons or markers                      |
| <input type="checkbox"/> Uses two hands together for activities (example: strings beads, takes caps off markers) | <input type="checkbox"/> Draws lines and circles                                |
| <input type="checkbox"/> Unscrews lids on containers   | <input type="checkbox"/> Turns pages of a book (one page at a time)             |
|  | <input type="checkbox"/> Squeezes objects such as small balls, play dough, etc. |

***What should we know about your child's fine motor skills?***

**Cognitive:** Thinking and early learning skills

Please check the boxes if your child can do this **most of the time**.

- |  |   |
|--|---|
| <input type="checkbox"/> Names objects and pictures of objects | <input type="checkbox"/> Listens to short stories                         |
| <input type="checkbox"/> Says first name                       | <input type="checkbox"/> Names colors                                     |
| <input type="checkbox"/> Points to body parts                  | <input type="checkbox"/> Counts from 1-3                                  |
| <input type="checkbox"/> Sings familiar songs                  | <input type="checkbox"/> Indicates wants by using gestures and vocalizing |
| <input type="checkbox"/> Names common shapes                   |   |

***What should we know about your child's cognitive skills?***

**Self Help:** Eating, dressing, toileting skills

Please check the boxes if your child can do this **most of the time.**

- |  |  |
|--|--|
| <input type="checkbox"/> Chews and swallows food without choking | <input type="checkbox"/> Uses a spoon and fork         |
| <input type="checkbox"/> Takes off simple clothing               | <input type="checkbox"/> Is working on toilet training |
| <input type="checkbox"/> Uses a regular cup independently        | <input type="checkbox"/> Is toilet trained             |
| <input type="checkbox"/> Puts on simple clothing                 |  |

**What should we know about your child's self help skills?**

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**Social, Emotional and Behavior**

Please check the boxes if your child can do this **most of the time.**

- |  |   |
|--|---|
| <input type="checkbox"/> Shares                        | <input type="checkbox"/> Can calm or sooth self when upset      |
| <input type="checkbox"/> Takes turns                   | <input type="checkbox"/> Plays alongside other children         |
| <input type="checkbox"/> Follows simple directions     | <input type="checkbox"/> Plays with other children              |
| <input type="checkbox"/> Plays pretend or make-believe | <input type="checkbox"/> Can use words when upset or frustrated |

**What should we know about your child's social skills, emotions, personality, and behavior?**

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**Communication:**

Do you feel your child has a speech problem?  Yes  No

If yes, please describe:

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What percentage of your child's speech do you understand? \_\_\_\_\_

How much of your child's speech do others understand? \_\_\_\_\_

Is your child's behavior affected by communication challenges?  Yes  No

Check if your child does any of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> Repeats sounds, words or phrases, over and over           | <input type="checkbox"/> Communicates by using gestures, pointing, and/or sign language |
| <input type="checkbox"/> Understands what you are saying                           | <input type="checkbox"/> Communicates using sounds (vowels, grunting)                   |
| <input type="checkbox"/> Responds correctly to yes and no questions                | <input type="checkbox"/> Communicates using single words (shoe, doggy, up)              |
| <input type="checkbox"/> Responds correctly to who, what, where, and why questions | <input type="checkbox"/> Communicates using 2 to 4 word sentences                       |
| <input type="checkbox"/> Communicates with body language                           | <input type="checkbox"/> Communicates using sentences longer than four words            |

**What should we know about your child's communication skills?**

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Who completed this form? \_\_\_\_\_ Date: \_\_\_\_\_

Please attach a copy of your child's birth certificate and email, fax or mail this form to:

*Debbie Pugh, EISC, 5530 E. Northern Lights, Anchorage AK 99504*

Fax: 742-2660, [eisc@asdk12.org](mailto:eisc@asdk12.org) Revised 9/19