PRESCHOOL/EARLY INTERVENTION QUESTIONNAIRE

CHILD'S NAME:	**DOB:**
NAME OF PROGRAM	**ADDRESS OF PROGRAM:**
HOW OFTEN ATTENDS? _____ DAYS/WEEK _____ HOURS/DAY	
HOW LONG HAS YOUR CHILD ATTENDED THIS PROGRAM?	
NUMBER OF CHILDREN IN CLASSROOM:	**STAFF RATIO:**

Please Check Type of Program(s) Child Attends:

CHILD CARE PROGRAM:	**HOME-BASED PROGRAM:**
NURSERY SCHOOL:	**CENTER-BASED INTERVENTIONAL PROGRAM**
SPECIAL EDUCATION PRESCHOOL:	**OTHER (PLEASE EXPLAIN)**
INTEGRATED PRESCHOOL:	

Has this child been reviewed by Committee on Preschool Special Education (CPSE)? YES / NO	
IF YES/ WHEN?	**WERE THEY CLASSIFIED? YES / NO**
CHILD'S SCHOOL DISTRICT:	**DOES CHILD RECEIVE SERVICES (PHYSICAL THERAPY, COUNSELING, ETC.) YES / NO**

If yes, please identify service(s) received and how often services are delivered?

SERVICES RECEIVED	TYPE OF SERVICE DIRECT, INDIRECT, INDIVIDUAL, GROUP	FREQUENCY & LENGTH OF SERVICE (DAYS, WEEKS)	PUSH IN/PULL OUT
Speech/Language Therapy			
Occupational Therapy			
Physical Therapy			

Special Education **SEIT (Sp. Ed. Itinerant Teacher)** **Ages 3-5 yrs. or** **Sp. Instruction for ages Birth – 2 yrs.**			
OTHER:			

DOES THE CHILD HAVE A 12-MONTH PROGRAM OR RECEIVE SERVICES DURING SUMMER? YES / NO
DOES CHILD HAVE AN INSTRUCTIONAL TEAM WITH ASSIGNED CASE MANAGER? YES / NO

PREVIOUS EVALUATIONS (PLEASE ATTACH EVALUATIONS TO THIS FORM)

NAME	**DATE**	**RESULTS:**
PSYCHOLOGICAL		
EDUCATIONAL		
SPEECH/LANGUAGE		
OCCUPATIONAL THERAPY		
PHYSICAL THERAPY		
OTHER		

PLEASE COMMENT ON THE FOLLOWING AREAS:

VISION/HEARING
VERBAL EXPRESSION/ABILITY TO COMMUNICATE (NOTE ANY STRENGTHS, PROBLEMS SUCH AS VOCABULARY, ORGANIZING, EXPRESSING IDEAS, ETC.):

AUDITORY PROCESSING (Note any strengths or problems such as following/understanding directions, understanding oral presentations)
FINE MOTOR, EYE-HAND COORDINATION, GROSS MOTOR SKILLS
ORGANIZATIONAL SKILLS
HOME/FAMILY ENVIRONMENT
SEPARATION FROM PARENTS OR ADULTS
QUALITY OF PLAY (ANY REPETITIVE PLAY OR RESTRICTED INTERESTS)?
ABILITY TO TRANSITION
SOCIAL-EMOTIONAL SKILLS
PEER RELATIONSHIPS
BEHAVIOR (Note if child exhibits symptoms of hyperactivity, impulsivity, distractibility, inattention, aggressive behavior, withdrawal, tantrums or other behavioral concerns) Please explain/describe)

HAS A FUNCTIONAL BEHAVIORAL ASSESSMENT (FBA) BEEN COMPLETED? YES / NO **IF YES, WHEN? _____ WHO COMPLETED IT? _____**
HAS A BEHAVIOR INTERVENTION PLAN BEEN DEVELOPED? YES / NO **IF YES, WHEN? _____ WHO DEVELOPED IT? _____**

DESCRIBE HOW THE CHILD WORKS/PLAYS UNDER THE FOLLOWING CONDITIONS:

ALONE	
SMALL GROUP	
LARGE GROUP	
QUIET ENVIRONEMNT	
LITTLE SUPERVISION	
FREE PLAY TIME	

INSTRUCTIONAL STRATEGIES (Indicate which methods or procedures you have found successful)

ABILITY TO PROFIT FROM CURRENT SERVICES/PROGRAMS:
WHAT ARE THE CHILD'S GREATEST STRENGTHS?
WHAT ARE THE MAIN ISSUES/CONCERNS ABOUT THIS CHILD?

QUESTIONS YOU WOULD LIKE ADDRESSED

Name(s) of persons completing this questionnaire:

Title/Position **Date**

Title/Position **Date**

Please return completed questionnaire to:

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