PRESCHOOL TRANSITION QUESTIONNAIRE

Please help us get to know your family and your child. We look forward to forming a collaborative relationship. Working together we can ensure that your child reaches his/her fullest potential. Thank you for taking the time to complete this Family Questionnaire.

CHILD INFORMATION	
Name of child	
Date of birth	
Age (start date)	

CHILD CARE:

What type of child care setting has your child experienced? (i.e. family caregivers, home daycare, centre based daycare)

HOME LIFE:

Who lives in your child's home? Who is the primary caregiver?	
Does your child have any siblings? Please indicate their names & ages.	
Have there been any major changes in the household since your child has been born? (i.e. new sibling, change in caregiver, etc.)	
Has your child been toilet	

trained? If so, for how long? Are there any issues in this area?	
How many hours does your child sleep both at night and during the day (naps)? What is their current sleep schedule?	
What is your child's native language?	
How many languages is your child exposed to at home?	

PERSONALITY:

How would you characterize your child's interaction with family members, friends, teachers, and other adult figures?

Please check all that apply.					
Shy		Cooperative		Strong-willed	
Outgoing		Creative		Easily distracted	
Playful		Curious		Moody	
Inquisitive		Defiant		Bossy	
Talkative		Demanding		Loving	
Sneaky		Perfectionist		Cautious	

Please indicate the frequency at which your child displays the following types of behaviours:

	Never	Often	Always
My child is generally in a positive mood			

My child quickly adapts to regular routines			
My child adapts easily to new experiences (new people, new places)			
My child is quick to form relationships with others			
My child enjoys being around other children			
My child enjoys being around adults			
My child prefers the company of others over being alone			

CHILD BACKGROUND INFORMATION:

I have had questions or concerns about my child's development in the following areas, at some point, since birth.

Check all that apply.

Medical and developmental		**Preschool experience**	
Motor development (i.e. walking, standing, sitting)		Struggled with drop-off (separation)	
Social development (i.e. eye contact, smiling, interactions, crying, babbling)		Participated in therapy (art, music, play therapy, physical therapy, speech, etc.)	
Any unexpected or sudden falls, emotional events, other major changes or traumas		Extended / intense tantrums (i.e. outbursts, pushing furniture, aggression)	
Recurring illnesses (ear infections, bronchitis, sinusitis, stomach ailments, etc.), fevers, surgeries, fussiness, sensitivities, etc.		Aggression toward adults or other students (i.e., kicking, hitting, shoving)	
A chronic condition (asthma, serious allergies, sickle cell, etc.		Issues with separation	

I WANT MY CHILD'S TEACHERS TO KNOW...

Please use the space below for any other comments, concerns, questions, or effective strategies that you use at home with your child.

Thank you for completing our questionnaire.
We look forward to getting to know your child!

Parent's Name (please print): _____

Parent's Signature: _____

Date: _____