

Prevention Initiative Parent Interview Form SAMPLE

Each program will individualize a Parent Interview Form with information regarding risk factors in their own community. This confidential form is intended to be completed in an interview with parent(s)/guardian(s) enrolling a child into the program. It is not to be given to the parent(s)/guardian(s) to complete. The completed Prevention Initiative Parent Interview Form will be used to complete the Preschool for All Eligibility Form. The program Parent Interview Form must correspond with Eligibility Form the program uses. The staff respond to the questions in writing as revealed by the parent/guardian. Some areas have lightly shaded wording to indicate the types of responses that belong in that space.

Person Interviewed:	Date:	Relationship to child:	
Child's full name (First, Middle, Last):		Date of birth:	
The name I would like my child to be called is:			
How did you hear about this program?			
1. Parent's name:		2. Parent's name:	
Date of birth:		Date of birth:	
Address:		Address:	
City:	State:	ZIP:	City: State: ZIP:
Phone:		Phone:	
Email:		Email:	
Marital status:		Marital status:	
Language spoken in home:		Language spoken in home:	
Translator - Yes/No (If yes, describe):		Translator - Yes/No (If yes, describe):	
Highest grade completed in school:		Highest grade completed in school:	
Place of employment:		Place of employment:	
Address:		Address:	
Phone number:		Phone number:	
Child lives with: <ul style="list-style-type: none"> <input type="radio"/> Parent(s)? <input type="radio"/> Foster parent(s) or legal guardian(s)? <input type="radio"/> Other (specify): Names (if other than parents):		List siblings:	Date of birth
Notes:		Are any of the child's siblings having academic difficulty or trouble in school? If yes, please explain:	

Do you notice, or has a doctor reported, any of the following in your child? (Circle)

<ul style="list-style-type: none"> • Thumb sucking • Nail biting • Epilepsy • Heart trouble • Overtired • Lack of appetite • Overweight • Underweight • Frequent headache • Nightmares • Asthma • Allergies (explain): 	<ul style="list-style-type: none"> • Frequent indigestion • Frequent constipation • Frequent diarrhea • Vomiting • Frequent Fevers • Sinus trouble • Nose bleeding • Rashes • Frequent ear infections • Night terrors • Communicable diseases (explain):
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Illness	Yes	No	Age	Hospitalization/Where
Measles				
Chicken Pox				
Mumps				
Strep Throat				
Tonsillitis				
Seizures				
Meningitis				
Whooping cough (pertussis)				

Question	Yes	No	Test Date	Test Result	Where
Does your child have a hearing problem?				Pass/Fail	
If yes, describe:					
Adaptive equipment (specify):					
Does your child have vision problems?				Pass/Fail	
If yes, describe:					
Adaptive equipment (specify):					
Has your child been diagnosed with a developmental concern?				Pass/Fail	
If yes, describe:					
Adaptive equipment (specify):					
List therapy services child has received.	Therapist		Agency/Clinic		Phone number

Social History

Please describe your child.

Does your child attend a child care program or in-home care?	Yes	No	Where:
Notes:			
Does your child have opportunities to play with other children?	Yes	No	Where:
Notes:			
Has your family experienced alcohol or drug abuse? If yes, please explain:			
Have you, or your child ever been exposed to stress, trauma, or violence? If yes, please explain:			
Is your family currently receiving services from the Department of Children and Family Services to resolve an abuse or neglect experience?			
Do any of the primary caregivers of this child have a chronic or terminal illness, mental illness, or a disability? If yes, please explain:			
Age of mother at birth of first child? _____ Age of father at birth of first child? _____			
Has your family recently immigrated? Yes/No If yes, please explain:			
Are any of the primary caregivers of this child on active duty in the military? Yes/No If yes, please explain:			
Are any of the primary caregivers of this child incarcerated? Yes/No If yes, please explain:			
Has there been a death in the immediate family(parent, child, sibling)? If yes, please explain:			
Do you have opportunities to socialize and interact with family and friends? Please explain:			
Is your family receiving services from another agency? Yes/No If yes, please explain:			
What are your child's most enjoyable activities?			
What do you enjoy doing as a family?			
What frightens your child?			
What do you do to comfort your child?			
When moving from one activity to another or transitioning, how does your child respond?			
What is a typical day like for you and your family?			
Do you believe your child's development is similar to that of the child's peers? Please explain:			
Have you noticed any regression in your child's development? Yes/No If yes, please explain:			

List significant people in your child's life (person/relationship):			
Does everyone in your family get enough to eat? Yes/No			
Do you have a place in your local community to get fresh food, such as fruits and vegetables? Yes/No If no, please explain:			
What is your child's eating/snacking schedule?			
What is your child's sleeping/napping schedule?			
Does your child have behaviors that concern you? Yes/No If yes, please explain:			
Describe any special information or instructions you would like program staff to be aware of:			
Current pregnancy?	Yes	No	Estimated date of delivery: _____ Date of last exam: _____
Are you experiencing any difficulties with this pregnancy? Yes/No If yes, please explain:			
Do you have any specific concerns about this pregnancy? Yes/No If yes, please explain:			
Please list physicians addressing this pregnancy.			
Doctor	Clinic/Office	Phone number	
Household Information			
Does your family have transportation available? Yes/No Notes:			
Please report the number of times the family has moved in the past year:			
What is your family's current living situation?			
<ul style="list-style-type: none"> ○ My family lacks a fixed, regular, and adequate nighttime residence. <ul style="list-style-type: none"> ▪ My family shares housing of other persons due to loss of housing, economic hardship, or a similar reason. ▪ My family lives in a motel, hotel, or camping grounds due to lack of alternative adequate accommodations. ▪ My family lives in emergency or transitional housing. ▪ My family's nighttime residence is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. ▪ My family lives in a car, park, public space, abandoned building, substandard housing, bus, or train station, or similar setting. ○ Child is awaiting foster care placement. ○ I am an unaccompanied youth. I am not in the physical custody of a parent or guardian. 			

(This includes runaways living in runaway shelters, abandoned buildings, cars, on the streets, or in other inadequate housing; children and youth denied housing by their families; and school-age unwed mothers living in homes for unwed mothers because they have no other housing available.)

As a parent, do you feel that reading and comprehension is easy or difficult for you? (Circle)
 EASY DIFFICULT

Household structure: <ul style="list-style-type: none"> <input type="radio"/> Both parents at home <input type="radio"/> Single parent at home <input type="radio"/> Adult other than parent (guardian, grandparent) also in the home <input type="radio"/> Shared custody (part time with mom/part time with dad) <input type="radio"/> Teen parent lives with parents <input type="radio"/> Other situation (specify): 	Notes:
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Employment Status (Check appropriate box for each parent)	Parent 1	Parent 2
Unemployed, not seeking employment (includes full-time homemaker)		
Unemployed, seeking employment		
Employed less than 20 hours per week		
Employed 20 hours or more per week		

Educational Status	Parent 1	Parent 2
Current student		

If yes, please explain:

Financial Information

Please report the household annual income:	Report the number of people living in the household:
Public Programs: <ul style="list-style-type: none"> <input type="checkbox"/> Women, Infants, and Children (WIC) <input type="checkbox"/> Medicaid Card (must be in parent name) <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) <input type="checkbox"/> Child Care Assistance Program (CCAP) 	Proof of Income (required only if no proof of public benefits above): <ul style="list-style-type: none"> <input type="checkbox"/> Paystubs <input type="checkbox"/> SSI <input type="checkbox"/> Other form of income verification – Describe:

Insurance Information	Yes	No
My family is enrolled in PRIVATE medical insurance from parent's work.		
My family is enrolled in All Kids.		
My family is enrolled in Medicaid.		
My family has NO medical insurance.		
My family has other insurance arrangements. Please specify:		
My family is covered in the event of another pregnancy.		

What are your dreams or goals for your child's future?
Please provide any other information that will help us serve you and your family better.

The information provided is true and accurate to the best of my (our) knowledge.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Staff Signature

Date

Use the header and footer to insert page numbers, label, and add a date the form was created or revised.