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| **Preschool for All Sample Parent Interview Form** (Confidential) |
| Instructions: This is a sample. Each program will individualize a parent interview form with information regarding risk factors in their own community. This form is intended to be completed in an interview with the parent(s)/guardian(s) enrolling the child into the program. It is not to be given to the parent(s)/guardian(s) to complete. The completed PFA Parent Interview form will be used to complete the PFA Eligibility form. This sample Parent Interview form corresponds with Sample Eligibility form. 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):  | (Circle)Boy or Girl | Date of birth: |
| The name I would like my child to go by is:  |
| How did you hear about this program?  |
| Mother’s name (or significant female):  | Father (or significant male) |
| 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: |
| Highest grade completed in school: | Highest grade completed in school: |
| Place of employment: Address: Phone number:  | Place of employment:Address: Phone number:  |
| Does the child live with his/her * Parent(s)?
* Foster parent(s) or legal guardian(s)?
* Other (specify):

Names (if other than parents):  | List siblings: | Date of birth |
| Sibling | Date of birth |
| Sibling | Date of birth |
| Sibling | Date of birth |
| Sibling | Date of birth |
| Sibling | Date of birth |
| Notes:  | Are any of the child’s siblings having academic difficulty or trouble in school? If yes, please explain:  |
| **Child’s Medical History** |
| Was there anything unusual about the pregnancy or delivery of this child or did he/she experience any serious health problems at birth? Yes/NoIf yes, please explain: |
| Was there any drug or alcohol use during this pregnancy? Yes/NoIf yes, please describe:  |
| Length of this pregnancy: |
| Weight of child at birth: | Current weight: | Current height: |
| Did this child experience feeding difficulties as an infant? Yes/NoIf yes, please explain: |
| Was this child on a respirator? Yes/No | If so, how long?  |
| Is your child experiencing health issues? (Please indicate if the illness is chronic or terminal.) If yes, please explain:  |
| Does your child have a diagnosed disability? If yes, please explain: |
| This child needs a referral to Child and Family Connections. Yes/No |
| Is this child taking any medication(s)? Yes/NoWhat medication(s) is this child taking? |
| Why is this child taking medication? Condition(s) |
| Please list any surgeries for this child. | Date | Hospital |
| Surgery | Date | Hospital |
| Surgery | Date | Hospital |
| Surgery | Date | Hospital |
| Surgery | Date | Hospital |
| Surgery | Date | Hospital |
| * Please list the name(s) and contact information of the doctor(s) for this child.
 |
| Doctor | Clinic/Office  | Phone number |
| Doctor | Clinic/Office | Phone number |
| Doctor | Clinic/Office | Phone number |
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| Doctor | Clinic/Office | Phone number |
| Do you notice, or has a doctor reported any of the following in your child? (Circle)  |
| * Thumb sucking
* Nail biting
* Epilepsy
* Heart trouble
* Overtired
* Lack of Appetite
* Overweight
* Underweight
* Frequent headache
* Nightmares
* Asthma
* Allergies (explain):

  | * Frequent indigestion
* Frequent constipation
* Frequent diarrhea
* Vomiting
* Frequent Fevers
* Sinus trouble
* Nose bleeding
* Rashes
* Frequent ear infections
* Night terrors
* Communicable diseases (explain):
 |
| **Illness** | **Yes** | **No** | **Age** | **Hospitalization/Where** |
| Measles | Yes | No | Age | **Hospitalization/Where** |
| Chicken Pox | Yes | No | Age | **Hospitalization/Where** |
| Mumps | Yes | No | Age | **Hospitalization/Where** |
| Strep Throat | Yes | No | Age | **Hospitalization/Where** |
| Tonsillitis | Yes | No | Age | **Hospitalization/Where** |
| Seizures | Yes | No | Age | **Hospitalization/Where** |
| Meningitis | Yes | No | Age | **Hospitalization/Where** |
| Whooping cough (pertussis) | Yes | No | Age | **Hospitalization/Where** |
| Question | Yes | No | Test Date | Test Result | Where |
| Does your child have a hearing problem?  | Yes | No | Test Date | Pass/Fail | Where |
|  If yes, describe:  |
|  Adaptive equipment (specify):  |
| Does your child have vision problems?  | Yes | No | Test Date | Pass/Fail | Where |
|  If yes, describe:  |
|  Adaptive equipment (specify): |
| Has your child been diagnosed with a developmental concern?  | Yes | No | Test Date | Pass/Fail | Where |
|  If yes, describe:  |
|  Adaptive equipment (specify): |
| List therapy services child has received. | Therapist  | Agency/Clinic | Phone number  |
| Type of therapy | Therapist  | Agency/Clinic  | Phone number  |
| Type of therapy | Therapist | Agency/Clinic | Phone number  |
| Type of therapy | Therapist | Agency/Clinic | Phone number  |
| Type of therapy | 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/NoIf 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 his/her peers? Please explain:  |
| Have you noticed any regression in your child’s development? Yes/NoIf 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? 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/NoIf yes, please explain:  |
| Please list physicians addressing this pregnancy.  |
| Doctor | Clinic/Office | Phone number |
| Doctor | Clinic/Office | Phone number |
| Doctor | Clinic/Office | Phone number |
| Doctor | Clinic/Office | Phone number |
| **Household Information** |
| Does your family have transportation available? Yes/NoNotes:  |
| Please report the number of times the family has moved in the past year:  |
| What is your family’s current living situation: * My family lacks a fixed, regular, and adequate nighttime residence.
* 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, 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: * Both parents at home
* Single parent at home
* Adult other than parent (guardian, grandparent) also in the home
* Shared custody (part time with mom/part time with dad)
* Teen parent lives with his/her parents

Other situation (specify): | Notes: |
| Employment Status(Check appropriate box for each parent) | Mother | Father |
| Unemployed, not seeking employment (includes full-time homemaker)  | Mother | Father |
| Unemployed, seeking employment  | Mother | Father |
| Employed less than 20 hours per week  | Mother | Father |
| Employed 20 hours or more per week  | Mother | Father |
| Educational Status  |
| Current Student  | Mother | Father |
| If yes, please explain:  |
| **Financial Information** |
| Please report the household annual income:  | Report the number of people living in the household:  |
| Insurance Information | Yes | No |
| My family is enrolled in PRIVATE medical insurance from parent’s work.  | Yes | No |
| My family is enrolled in KidCare.  | Yes | No |
| My family is enrolled in Medicaid.  | Yes | No |
| My family has NO medical insurance.  | Yes | No |
| My family has other insurance arrangements. Please specify:  | Yes | No |
| My family is covered in the event of another pregnancy.  | Yes | No |
| 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.  |
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| 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 |
| Other helpful tips: * Use the header and footer to insert page numbers, label, and add a date the form was created or revised
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