__________________, ________________________
First Name *Last Name*

Austin T. Levy School
Parent Interview Form

OPTIONAL INFORMATION

(This information is helpful for state reporting)

Social Security # ______________________________

Race/Ethnicity:

☐Native American ☐Asian ☐Black (Not Hispanic) ☐Hispanic ☐ White (Not Hispanic)

HISTORY

This child is 1 2 3 4 5 6 ***out of*** 1 2 3 4 5 6 children? (circle)

Was there any significant delay in the following developmental milestones? If yes, please check and explain.

☐ sat alone	☐ spoke first words
☐ crawled	☐ 2 or 3 sentences
☐ walked	☐ fed self
☐ rode tricycle	☐ toilet trained

____

____

Does your child display signs of difficulty in any area listed below? If yes, please check and explain.

☐ vision	☐ expressive language
☐ hearing	☐ following directions
☐ speech	☐ maintaining attention
☐ sleeping	☐ eating habits

____

____

____

Does your child display problems in accomplishing the following tasks?

Hold a crayon and draw lines?	Yes ☐	No ☐
Use alternate feet walking up or down stairs?	Yes ☐	No ☐
Zip a zipper?	Yes ☐	No ☐
Cut with scissors?	Yes ☐	No ☐
Fasten buttons?	Yes ☐	No ☐

Describe your child’s movement patterns (i.e. awkward, clumsy, active, agile, quick, slow, sure, hesitant, on the go, etc.).

____

____

Which hand does your child use when eating?	Right ☐	Left ☐
Does your child become upset when away from you for three or four hours?	Yes ☐	No ☐

Is your child hesitant or afraid to mix
with other children? Yes ☐ No ☐

Does your child display strong reactions to
discipline (i.e. temper tantrums, etc.)? Yes ☐ No ☐

Please describe your child's personality. (e.g. shy, outgoing, cries easily, even tempered, bossy, talkative, immature, fearful, etc.)
____
____

MISCELLANEOUS
Previous schools attended: ____

____

Has your child been involved in "*Early Intervention*"? ______Yes _____ No
Has your child attended a "*Headstart/Preschool*" program? ______Yes______No
Has your child been screened by "*Child Outreach*"? ______ Yes _____No _______
Please describe the type of program they experienced: Date
____
____

Has your child received *Occupational Therapy*? ______ Yes ______ No
If so, where? __________________________ When? __________________
Has your child received *Physical Therapy*? ______ Yes ______ No
If so, where? __________________________ When? __________________
Has your child received *Speech/Language Therapy*? ______ Yes ______ No
If so, where? __________________________ When? __________________

Brothers and Sisters (please list):

Name(first and last)	*Date of Birth*	*Sex*	*Health*	*School*

HEALTH

Family Physician or Pediatrician: ______________________________________
Address: ______________________________________
Phone: ______________________________________

Child's Birthplace: ______________________________________

Birth Weight: _____________ Full Term? ☐ Yes ☐ No

If premature, give details

____

____

Did this child require any special medical care at birth or during the first month?

☐ YES ☐ NO

If yes, explain: ____

____

Is your child on any medications? ☐ Yes ☐ No

If yes, please list them: ____

____

Does your child have allergies?

To medications?	☐ Yes	☐ No	List: ______________________
To foods?	☐ Yes	☐ No	List: ______________________
To Bee Stings?	☐ Yes	☐ No	
Others?	☐ Yes	☐ No	List: ______________________

Does your child have any of the following?

☐ Asthma	☐ Indigestion	☐ Headaches
☐ Seizure Disorder	☐ Constipation	☐ Nightmares
☐ Eczema	☐ Diarrhea	☐ Thumbsucking
☐ Heart Disease	☐ Frequent fevers	☐ Nail biting
☐ Diabetes	☐ Sinus trouble	☐ Overtired or lacking pep
☐ Glasses	☐ Nose bleeding	☐ Vomiting

☐ Other physical problems (explain):

____

____

____

Has he/she experienced any serious accidents?	☐ Yes	☐ No
serious illnesses?	☐ Yes	☐ No
hospitalizations?	☐ Yes	☐ No

If yes, please explain____

Does your child have a history of:

Repeated ear infections?	☐ Yes	☐ No
Hearing problems?	☐ Yes	☐ No
Vision Issues?	☐ Yes	☐ No

Has this child ever had any ear/hearing examination or treatment? ☐ Yes ☐ No

If yes, who did the exam? ________________________ When was the exam done? __________
What were the results? ____
____

Has this child ever had a vision examination or treatment? ☐ Yes ☐ No
If yes, who did the exam? ________________________ When was the exam done? __________
What were the results? ____
____

Do you have any health concerns about your child at this time? ☐ Yes ☐ No
If yes, please explain:____
____
____

Parent/Guardian Signature: ____

Date: ______________________