Parental Concerns Questionnaire

Parent Name: _____ Child Name:_____

Directions: ***Please mark <u>all</u> your concerns from the following list with and X.***

____ 1. Behavior. My child:
- ____ has tantrums
- ____ is not able to accept limits
- ____ resists rules or refuses to comply with requests

____ 2. Socialization. My child:
- ____ does not play with other children
- ____ does not separate from me easily
- ____ will not work in a group
- ____ is left out of activities with other children

____ 3. Speech/Language. My child:
- ____ has unclear or garbled speech
- ____ has difficulty expressing wants
- ____ uses incomplete sentences
- ____ needs instructions repeated often
- ____ repeats what she or he says
- ____ doesn't remember simple information from day to day
- ____ gives inappropriate answers to questions

____ 4. Self-Help. My child:
- ____ has toileting difficulties
- ____ has difficulty feeding or dressing himself or herself
- ____ has difficulty following routines

____ 5. Attention. My child:
- ____ is easily distracted
- ____ has a short attention span
- ____ darts from one task to another
- ____ persists when asked to stop

____ 6. Developmental Abilities. My Child:
- ____ does not appear to be learning at an average rate
- ____ has had delays in developmental milestone
- ____ does not seem to understand well
- ____ acts much younger than his or her age
- ____ seeks much younger friends

____ 7. Motor. My child:
- ____ is clumsy
- ____ has difficulty using pencils, crayons, or scissors
- ____ has difficulty buttoning or zipping
- ____ has hand/eye coordination problems
- ____ has poor control of body movements

____ 8. Hearing. My child:
- ____ has trouble hearing
- ____ asks people to repeat or talk louder
- ____ favors one ear over the other
- ____ is startled at sudden noises
- ____ has earaches
- ____ speaks loudly
- ____ watches a person's face when that person talks

____ 9. Vision Problems. My child:
- ____ has eyes that turn in
- ____ has eyes that turn out
- ____ squints
- ____ tilts his or her head
- ____ wants to sit too close to the TV
- ____ hold books very close to his or her face
- ____ blinks a lot
- ____ rubs his or her eyes

____ 10. Medical/Health Related. My child:
- ____ has been in the hospital _____ times
- ____ has had serious illnesses
- ____ has had accidents

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