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Early Learning Academy
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Early Learning Academy

Parental Concerns Questionnaire

Parent Name: _____ **Child Name:** _____

Directions: ***Please check <u>all</u> your concerns from the following list.***

___ 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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