Child's Name
Date of Birth

Age Zero to 5 years
Therapists and Teachers Questionnaire

DEAR PARENT:

Please give the attached questionnaire to your child's Early Supports and Services (ESS) agency or Preschool program.

If your child is not in ESS or a Preschool, give one copy of this form to each therapist who works with your child's development (for example: speech, occupational, or physical therapist).

Ask them to complete the form and return it to our office as soon as possible, prior to your appointment here.

If your child is not receiving any services, please write that on this page and send this page back.

IMPORTANT:
Please also send the reports of any *evaluations* done by ESS or therapists.

The questionnaires will be reviewed by staff at Elliot Developmental Pediatrics who will be involved in your child's evaluation.

Please note that all information is kept strictly confidential.

Please call if you have any questions.
Phone: 603-663-3222

Once the form is completed it should be returned to:

Elliot Developmental Pediatrics
275 Mammoth Rd
Manchester, NH 03109

Or fax to: 603-663-3229

Child's Name
Date of Birth

Name of Program ____

Who completed this questionnaire?
Name ____
Title ____

Name ____
Title ____

Name ____
Title ____

DATE_______________________________

WHAT QUESTIONS WOULD YOU LIKE TO HAVE ADDRESSED?
____
____

What are this child's strengths?____
____

What are the challenges you see?____
____

PLEASE ATTACH ALL EVALUATION REPORTS and IFSP or IEP TO THIS QUESTIONNAIRE

Does this child have private (parent or insurance pay) therapies? Yes No
Started (date) ____
Location (home, hospital, private clinic) ____

Has child been referred for Early Supports and services? Yes No
When ____
Does child have an IFSP? Yes No

Has child been referred to District Special education preschool? Yes No
When ____
Does child have a Preschool IEP? Yes No

Name and address of current out of home program None
____
Services started (date) ____

Child's Name
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Program	Attends Y/N	Class size	# Teachers
Child Care			
Nursery School			
Preschool private			
Integrated preschool (district)			
Special Education Preschool (district)			

Attends ______hours for ______days per week

For Early Supports and Services/Early intervention
All services in home?: yes no
Services at program/center based: yes no
Combined home based and center based: yes no

Services

Type	Type of service consult, individual, group	Frequency eg min / week	Home/ push in or out
Speech			
OT			
PT			
Counseling			
Spec Ed			
Other			

PLEASE COMMENT ON:
1.Vision____
Hearing ____

2. Communication skills
Receptive (follows directions, knows names etc. ___________________________
____

Expressive (able to make needs known, can be understood?) ________________
____

3. Motor Skills
Gross motor ____

Child's Name
Date of Birth

Fine motor ____

Coordination and planning ____

4. Social
Peer Interaction ____
____

Adult interaction____
____

Parent (separation issues, engagement)_______________________________________

Home environment ____

5. Behaviors that are a concern ____
____

6. Play and engagement skills
Alone ____

Small group ____

Large group ____

Adult directed ____

Quiet time ____

Free play ____

Please return this form and **attached testing reports** to the family or directly to
Elliot Pediatric Specialties
Developmental Pediatrics
275 Mammoth Rd
Suite One
Manchester NH
FAX 603-663-32

THANK YOU