Early Head Start Family Questionnaire

This questionnaire must be completed with families.

Child Name: _____ **Date:** _____

Classroom/Site: _____ **Person Completing Form:** _____

What do you enjoy most about your child?
What are you most proud of about your child?
Where is your child's favorite place to play?
What is your child's likes and preferences *(foods, toys, and people)?*
What is your child like at home? Mood? Behavior?
What does a good day look like with your child? What is the hardest part of the day?

What activities do you most like to share with your child?
How do see your child compared to other children?
Does your child have any fears or worries we should be aware of?
What does your child do when upset and how are they best comforted?
How does your child let you know they are hungry? Tell me about feeding. Time of day, how and what time of day, and what you feed your child? How do you know they are full?
Tell me about your child's sleeping patterns. When does he/she sleep? Time of day and for how long? Do you have a special sleeping routine (i.e. singing songs, reading books)? Does your child have a favorite item they use for comfort?
How would you like me to communicate with you about your child's day? *(Email, phone, before or after class)*