The Chickasaw Nation Head Start
Parent Interview

Interviewer will complete highlighted questions. Enrollment will be completed at the interview.

Student name: ________________________ Birth date: ____________ ☐ IE ☐ OI

Enrollment date: ____________ Entry date: ____________ Dropped date: ____________

Years of Head Start: _______ Center: ______________________ Classroom: ______________

Home school district: ____

Gender: ☐ Male ☐ Female CDIB or other tribal documentation: ☐ Yes ☐ No

Tribe: ____________________________________ Degree: _________

Parent/guardian: ____

Address: ____

Email address: ____

Home phone: ____________ Work phone: ______________ Cell phone: ______________

Legal guardianship documentation form **(bring documentation to enrollment):**

☐ Official birth certificate Parent DL confirmation	☐ Divorce decree dated: ___/___/___	☐ Custody court order dated: ___/___/___
☐ Foster care letter dated: ___/___/___	☐ Witnessed and notarized parent n	☐ Temporary custody order dated: ___/___/___
	dated: ___/___/___	

Emergency Contacts:

Relationships	Name	Address/Town	Phone

Other:

Bus: ☐ a.m. ☐ p.m. ☐ Brought to school ☐ Picked up ☐ CNDH After School

☐ Other child care (list name): ______________________ Phone no. ____________

Pick-up/drop-off restriction: ____

Are there any health concerns? ☐ Yes ☐ No If yes, explain: ______________________

____

____

Date of child's last physical exam prior to enrollment: ______________________

Date of child's last dental exam prior to enrollment: ______________________

Date of the interview: ______________________ Interviewer: ______________________

Updated on: ______________________ Updated by staff: ______________________

Re-enrollment interview: ______________________ Interviewer: ______________________

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Established medical home at enrollment: ☐ Yes ☐ No

Established dental home at enrollment: ☐ Yes ☐ No

Medical coverage and policy ID number: ______________________________

Routine medications: ______________________________

Allergies: ______________________________

Current Physician	Current Dentist
Place address and phone number label here	Place address and phone number label here
Preferred Clinic	**Preferred Hospital**
Place address and phone number label here	Place address and phone number label here

Describe the child's use of communication/language: ______________________________

____

Did the mother have any health problems during the pregnancy? ☐ Yes ☐ No

Explain: ______________________________

Baby was born: ☐ full-term ☐ early; by: _____ weeks ☐ late; by: _____ weeks

Explain: ______________________________

What was the child's birth weight and length?

weight: ________ pounds ________ ounces length/height: ________ inches: ________

Describe any problems at birth: ______________________________

____

What accidents has the child experienced? ______________________________

____

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What serious illnesses has the child had, if any? ____

____

The child's milestones: (indicate with the number of months of age)

	When did child begin to ________?	Age of mastery	Parent concern
Crawling			
Standing			
Walking			
Talking			
Feeding self			
Dressing self			
Scribbling			
Potty training			
Follow simple instruction			

Expectation ranges for milestones skills to be observed:

- Hearing and speech capacity is fully developed after three months
- Vision capacity is fully developed after seven months
- Crawling six to nine months
- Standing eight to 12 months
- Walking nine to 18 months
- Talking 12 to 24 months
- Feeding self 10 to 18 months
- Dressing self 24 to 36 months
- Scribbling 12 to 36 months
- Potty training 12 to 36 months
- Following simple commands 18 to 24 months

Does the child have difficulty seeing? ☐ Yes ☐ No

Does the child wear prescription glasses? ☐ Yes ☐ No

Who prescribed the eyewear? ____

How is eyewear to be worn? ____

What ear problems, if any, has child had? ____

____

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Has the child ever been seen in the emergency room or been hospitalized/or admitted for surgery?

☐ Yes ☐ No If yes, explain: ____

____

Does the child have frequent? (Check all that apply)

☐ Cough	☐ Sore throats	☐ Eye/ear infections
☐ Colds	☐ Stomach aches	☐ Vomiting
☐ Diarrhea	☐ Constipation	☐ Rash
☐ Toileting accidents	☐ Urinary infections	☐ Bruises
☐ Insect bites	☐ None at this time	

Has the child had any of these? (Check all that apply)

☐ Chicken pox	☐ Eczema	☐ Measles	☐ Mumps
☐ Scarlet fever	☐ Sickle cell	☐ Liver disease	☐ Boils
☐ Whooping cough	☐ Hives	☐ Pin worms	☐ Transfusions
☐ Heart problems	☐ Diabetes	☐ Polio	☐ Bleeding tendencies
☐ Ulcers	☐ Pneumonia	☐ Dental pain	☐ Major injuries
☐ Broken bones	☐ Cancer	☐ Kidney problems	☐ Rheumatoid arthritis
☐ Scoliosis	☐ High fever	☐ Syndrome diagnosis (______________________)	

☐ Contagious disease (explain, if not listed above): ______________________________________

____

☐ None noted at this time (items added after the initial interview will be dated and initialed at the time of the addition).

How often does the child follow directions well? ☐ Most of the time ☐ Not very often ☐ Sometimes

____

What chores does the child do at home? ______________________________________

____

____

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How does the child react to new environments? ______________________________

____

____

Who usually spends time with the child during the day? ______________________________

(identify the relationship to child) ______________________________

Describe the child's sleep pattern (sound, light, restless, etc.) ______________________________

Identify the hours that the child usually sleeps (the time range) ______________________________

Has the child been diagnosed as having a growth or weight issue? ☐ Yes ☐ No

If yes, explain: ______________________________

____

Describe what activities interest the child: ______________________________

____

____

Describe the length of the child's attention span: ______________________________

____

What type of toy does the child prefer? ______________________________

____

____

Do you have any specific concerns or questions about the child attending Head Start at this time?

☐ Yes ☐ No, not at this time

If yes, explain: ______________________________

____

____

____

____

____

____

____

____

____

____

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Rate the following areas by placing a check mark beneath the response that best describes the child's preference or behavior in the situation:

	Areas of Consideration:	Often	At times	Seldom	Not Observed
1	Listens and follows directions quickly	☐	☐	☐	☐
2	Expresses feelings and mood changes appropriately	☐	☐	☐	☐
3	Expresses affection to familiar people	☐	☐	☐	☐
4	Is friendly and smiles a lot	☐	☐	☐	☐
5	Is happy and carefree	☐	☐	☐	☐
6	Is sad	☐	☐	☐	☐
7	Is scared easily	☐	☐	☐	☐
8	Is resourceful and independent	☐	☐	☐	☐
9	Is very shy and bashful	☐	☐	☐	☐
10	Wants help and gets frustrated without assistance	☐	☐	☐	☐
11	Feels the need to fight or argue	☐	☐	☐	☐
12	Has moved more than one time	☐	☐	☐	☐
13	Has had a family pet that ran away or died recently	☐	☐	☐	☐
14	Has had a family member die recently	☐	☐	☐	☐
15	Lives with only one parent now	☐	☐	☐	☐
16	Has close relationship with grandparent	☐	☐	☐	☐
17	Speaks clearly	☐	☐	☐	☐
18	Throws tantrums	☐	☐	☐	☐
19	Worries about getting embarrassed	☐	☐	☐	☐
20	Likes to play indoors in dark places	☐	☐	☐	☐
21	Likes to play indoors in places with a lot of light	☐	☐	☐	☐
22	Likes noisy places	☐	☐	☐	☐
23	Likes quiet places	☐	☐	☐	☐
24	Likes very warm temperature indoors	☐	☐	☐	☐
25	Likes very cold temperature indoors	☐	☐	☐	☐
26	Chooses from more than two choices	☐	☐	☐	☐
27	Transitions to new tasks or situations	☐	☐	☐	☐
28	Likes to pretend and has a good imagination	☐	☐	☐	☐
29	Likes to listen to a book	☐	☐	☐	☐
30	Likes to use scissors and glue	☐	☐	☐	☐
31	Takes turns with one person	☐	☐	☐	☐
32	Likes to help others	☐	☐	☐	☐
33	Likes to talk	☐	☐	☐	☐
34	Likes to tell stories	☐	☐	☐	☐
35	Likes to sing songs	☐	☐	☐	☐
36	Likes to play outdoors with more than one person	☐	☐	☐	☐
37	Likes to look at books	☐	☐	☐	☐
38	Likes to draw	☐	☐	☐	☐
39	Is a picky eater	☐	☐	☐	☐
40	Likes to stack blocks	☐	☐	☐	☐
41	Shares with one or more people	☐	☐	☐	☐
42	Answers questions about stories	☐	☐	☐	☐
43	Performs on cue	☐	☐	☐	☐
44	Remains belted during car rides	☐	☐	☐	☐

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Dietary Habits:

1. What foods does your child especially like to eat?

2. Are there any foods your child dislikes or should not eat?

Read the question and place a check mark beneath the appropriate response.	Yes	No
3. Does your child take vitamins and mineral supplements?	☐	☐
a.) Contain iron?	☐	☐
b.) Contain fluoride?	☐	☐
c.) Prescribed?	☐	☐
4. Is there any food your child should not eat for medical, religious or personal reasons?	☐	☐
5. Is your child on a special diet?	☐	☐
a.) What kind?		
6. Has there been a big change in your child's appetite in the last month?	☐	☐
7. Does your child take a bottle?	☐	☐
8. Does your child eat or chew things that are not food?	☐	☐
9. Does your child have trouble chewing or swallowing?	☐	☐
10. Does your child often have:		
a.) Diarrhea?	☐	☐
b.) Constipation?	☐	☐
11. Do you have any concerns about what your child eats?	☐	☐

Check the numeral that best approximate number of servings the child eats per week	
12. About how often does your child eat foods from each of the following groups:	
a.) Milk, cheese, yogurt	☐ 0* ☐ 1* ☐ 2* ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ +
b.) Meat, poultry, fish, eggs or dried beans/peas, peanut butter.	☐ 0* ☐ 1* ☐ 2* ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ +
c.) Rice, grits, bread, cereal, tortillas	☐ 0* ☐ 1* ☐ 2* ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ +
d.) Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes	☐ 0* ☐ 1* ☐ 2* ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ +
e.) Oranges, grapefruit, tomatoes, (fruit/juice)	☐ 0* ☐ 1* ☐ 2* ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ +
f.) Other fruits and vegetables	☐ 0* ☐ 1* ☐ 2* ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ +
g.) Oil, butter, margarine, lard	☐ 0* ☐ 1* ☐ 2* ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ +
h.) Cakes, cookies, sodas, fruit drinks, candy	☐ 0* ☐ 1* ☐ 2* ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ +

***Starred answers may require follow-up. Explain details or give additional comments here.**

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