OFFICE OF EARLY LEARNING:

CHILD AND FAMILY SOCIAL EMOTIONAL WELL-BEING QUESTIONNAIRE

Trauma results from an event or series of events that is experienced by an individual as physically or emotionally harmful or threatening and has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being – SAMHSA.

> **"Infants, toddlers, preschoolers, and young children who experience a tragic event may show changes in their behaviors. They may also be indirectly affected by a crisis by what they see on the TV or hear. Children of all ages easily pick up on their parents or other's fears and anxieties. This may cause changes in behaviors. Children, no matter what their age, do not always have the words to tell you how they are feeling. They may not know how to talk about what has happened. Their behavior can be a better sign. Sudden changes in behavior can mean they have been exposed to trauma or a crisis."**

-The National Center on Early Childhood Health and Wellness.

This is a basic questionnaire designed to help early childhood programs to identify children who may be affected by toxic stress/ trauma or crisis and are in need of further evaluation. The questionnaire is intended for the use of teachers, home visitors, family services workers and professionals who support young children and their families. The early childhood professional should incorporate parents' knowledge of their child and complete the form by collaborating with them. Answers to these questions will provide **Mental Health Coordinator and consultants** with a general idea of possible signs of concern, which will help our program act early and provide all necessary support to our children and their families.

Please use this questionnaire in your next visit or conversation with the parents, complete and submit it to **Disability and Mental Health Coordinator.**

NAME OF THE CHILD

AGE

CENTER HE/SHE ATTENDS

HOME-VISITING PROGRAM

PARENT INTERVIEWED

DATE

TEACHER/HOME VISITOR

I. CHILDREN

What changes, if any, have you seen in your child in the last two weeks?

1. SLEEPING HABITS/PATTERN

- ❑ Changes in Bedtime
- ❑ Nightmares
- ❑ Sleeping less
- ❑ Naptime
- ❑ Sleeping more
- ❑ Refusing to sleep (or fighting sleep)
- ❑ Other
- ❑ None of the above

Please explain:

2. EATING HABITS/PATTERN

- ❑ Schedule
- ❑ Eating more
- ❑ Eating less
- ❑ Snacking habits
- ❑ Eating non-food items (E.g., clay, paint chips, dirt, etc.)
- ❑ Changes at meal time (behavior, self-help skills)
- ❑ Other
- ❑ None of the above

Please explain:

3. TOILETING HABITS/PATTERN

- ❑ Toileting accidents
- ❑ Diarrhea
- ❑ Bed wetting
- ❑ Diapering
- ❑ Constipation
- ❑ Other
- ❑ None of the above

Please explain:

4. SCHEDULE/ROUTINE

- ❑ Resisting or some difficulties with transitions
- ❑ Not following or some difficulties with following directions (E.g., need to repeat)
- ❑ Needs additional support to complete routine/task
- ❑ Changes in previously acquired self-help skills (independence, self-care skills)
- ❑ Other
- ❑ None of the above

Please explain:

5. UNUSUAL/UNEXPECTED BEHAVIORS AND EMOTIONS

(Should be more than usual for that child)

- ❑ More frequent temper tantrums
- ❑ Crying/whining with no apparent reason
- ❑ Refusing to be comforted
- ❑ Aggressive/Engaging in fights with siblings or others
- ❑ Hard to be comforted (takes more time than usual
- ❑ Withdrawn/disengaged (E.g., looks bored)
- ❑ Clinging to parent/caregiver (separation anxiety)
- ❑ Loosing previously acquired skills
- ❑ Difficulties with concentration
- ❑ Trouble relaxing
- ❑ Becoming easily annoyed or irritated
- ❑ Other
- ❑ None of the above

Please explain:

For infants:

- ❑ More irritable than usual
- ❑ Wanting to be held and cuddled more

Please explain:

6. PLAY HABITS

- ❑ Socially withdrawn (wanting to be by themselves more than usually) and separated
- ❑ Aggressive or destructive play/activity (e.g. Throwing and breaking toys)
- ❑ Aggressive (anger, rage, excessive temper) toward peers or adults
- ❑ Other
- ❑ None of the above

Please explain:

7. **DOES YOUR CHILD HAVE ANY NEW HEALTH CONDITIONS PROBLEMS, AND/ OR ALLERGIES? OR DID ANY OF CHRONIC HEALTH PROBLEMS WORSENED?**

(E.g. Asthma, respiratory problems, digestive concerns, etc.)

❏ Yes ❏ No ❏ N/A

Please explain:

8. **ANY OTHER CHANGES NOT DESCRIBED ABOVE?**

❏ Yes ❏ No

Please explain:

II. PARENTS

9. **HOW ARE YOU DEALING WITH THIS NEW/ UNIQUE SITUATION?**

(How this new experience is affecting you?)

Please explain:

10. **WHAT CHANGES, IF ANY, HAVE YOU SEEN IN YOURSELF IN THE LAST TWO WEEKS?**

(E.g., sleeping, eating, mood, etc. related)

Please explain:

11. **ARE YOU FINDING THAT YOU ARE GETTING SOME TIME FOR YOURSELF?**

❏ Exercising ❏ Socializing

❏ Eating healthy ❏ Getting enough sleep

❏ Other ❏ None of the above

Please explain:

12. **HAVE YOU HAD ANY RECENT TRAUMATIC EXPERIENCES?**

(Death, severe illness, violence, lack of basic needs, etc.)

❏ Yes ❏ No

Please explain:

13. **IF YOU ARE BREASTFEEDING, DO YOU HAVE ANY CONCERNS ABOUT BREASTFEEDING?**

❏ Yes ❏ No ❏ N/A

14. **WOULD YOU LIKE TO TALK TO OUR MENTAL HEALTH CONSULTANT** *(if needed)*

❏ Yes ❏ No

Please explain:

If not, who is available to support you?

How can we better support you at this time?

THANK YOU!