



## "ABCD"

### Parent Survey

Date of contact \_\_\_\_\_

Child's name \_\_\_\_\_

Home phone number \_\_\_\_\_

Parent name \_\_\_\_\_

#### **For Questions 1 and 2-see SDBS measures-CAHMI Customize survey to your practice**

3- At your child's "well" visit, did you receive any written information on how children develop?

Yes \_\_\_\_\_ No \_\_\_\_\_ Unsure \_\_\_\_\_

4-Did you read the information? Yes \_\_\_\_ No \_\_\_\_ Did you find it helpful in understanding how children develop? Yes \_\_\_\_ No \_\_\_\_

5-Do you have suggestions on how you would like to receive information about child development in the future? *e.g. classes, healthfairs, brochures, etc.*

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6- If we offer programs or classes, are there any special needs you would have in regards to attending? \_\_\_\_\_, \_\_\_\_\_

*e.g. Transportation, babysitting, etc.*

7-Do you feel that knowing about child development has helped you in raising your child? Yes \_\_\_\_\_ No \_\_\_\_\_

*Comments* \_\_\_\_\_

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Thank you for your time and for sharing with us how you feel about the child development services your child receives at \_\_\_\_\_ (Practice Name)