FIRST 5 VENTURA COUNTY
Because the First 5 Years Impact a Lifetime!

Parent Survey

We want to learn if our services have helped you and your family. There are no right or wrong answers. Please answer the questions honestly. Your participation is voluntary and your responses will be kept private. Thank you!

I. HEALTH AND SCREENING

1. Do you have a usual place to go when your child is sick or you need health advice for your child?	❑ Yes	❑ No
2. Did your child have a routine check-up in the last 12 months (a doctor visit not related to illness or injury)?	❑ Yes	❑ No
3. Does your child currently have health insurance?	❑ Yes	❑ No

4. What is the regular place or doctor where you take your child for routine care and check-ups?

- ❑ Doctor's office, private clinic, or HMO
- ❑ Public health department or community health center/clinic
- ❑ Emergency room at a hospital
- ❑ Have never taken child for routine care
- ❑ Prefer not to say
- ❑ Other, please specify: _______________________

5. Did your child have a dental exam in the last 6 months?	❑ Yes	❑ No
6. Does your child have a regular dentist?	❑ Yes	❑ No

7. Since you started receiving First 5 services, has your child been referred for a Developmental Screening (for example, have you been asked to complete a checklist of activities that your child can do, such as certain physical tasks, whether your child can draw certain objects, or ways your child communicates with you)?	**❑ Yes ❑ No ❑ Don't know** If NO, skip to Question 8 below
a. If you received a referral, was a Developmental Screening conducted?	❑ Yes ❑ No If NO, skip to Question 8 below
b. If a Developmental Screening was conducted, was a concern identified?	❑ Yes ❑ No If NO, skip to Question 8 below
c. If a concern was identified, has your child received follow-up services?	❑ Yes ❑ No

II. ACTIVITIES

8. In the usual week, about how many days do you or any other family members read stories or look at picture books with your child? ❑ 1-2 days ❑ 3-4 days ❑ 5-6 days ❑ Every day ❑ Never

9. On an average weekday, about how much screen time does your child have (e.g. watching television or videos, or playing on the computer, phone, or tablet, etc.)?
❑ None ❑ 1 hour or less ❑ 2 hours ❑ 3 hours ❑ 4 hours or more

Please mark the answer that best describes you.	**Always**	**Most of the time**	**Some-times**	**Never**	**Does Not Apply to Me**
10. My **toddler or preschooler** is given 1-2 hours of physical activity each day (for example, playing outside, sports, dancing or running around).	❑	❑	❑	❑	❑
11. My child eats at least five servings of fruits and vegetables (such as bananas, apples, green beans, or green salad) over the course of the day.	❑	❑	❑	❑	❑

Please mark the answer that best describes you.	Always	Most of the time	Some-times	Never	Does Not Apply to Me
12. My child drinks water at meal times and throughout the day.	❑	❑	❑	❑	❑
13. How many glasses or cans of soda or other sweetened fruit drinks, sports, or energy drinks does your child drink over the course of the day?	❑ None	❑ 1	❑ 2	❑ 3 or more	❑ don't know

III. COMMUNITY RESOURCES

Thinking about you and your child **OVER THE PAST MONTH**, please mark the answer that best describes you.	Always	Most of the time	Some-times	Never	Does Not Apply to Me
14. I know how to get services that I need for my child.	❑	❑	❑	❑	❑
15. I am getting the services I need for my child.	❑	❑	❑	❑	❑
16. I talk to someone when I am worried about my child.	❑	❑	❑	❑	❑
17. I get my questions about parenting or child development answered.	❑	❑	❑	❑	❑
18. I have places I go to in my community to get the resources I need to support my family.	❑	❑	❑	❑	❑
19. I have places I go to in my community to meet with other parents.	❑	❑	❑	❑	❑

IV. PARENTING

Thinking about your interactions with your child **OVER THE PAST MONTH**, please mark the answer that best describes you.	Always	Most of the time	Some-times	Never
20. I understand my child's development.	❑	❑	❑	❑
21. I am able to tell if my child is making progress.	❑	❑	❑	❑
22. I know how to help my child develop and learn.	❑	❑	❑	❑
23. I know how to help my child behave the way my family would like.	❑	❑	❑	❑
24. I am able to help my child learn and practice new skills.	❑	❑	❑	❑
25. I know what to expect of my child based on her/his age.	❑	❑	❑	❑
26. I can handle problems that come up when taking care of my child.	❑	❑	❑	❑
27. I believe I have the skills for being a good parent to my child.	❑	❑	❑	❑
28. I am confident as a parent.	❑	❑	❑	❑

FOR STAFF USE ONLY

Program Name/Site: ________________________ Label for Client ID/Family ID here

DATE (MM/DD/YY):_________________