my CHILD'S therapy

Speech-Language Questionnaire

General Information:

Child's name: _____ Child's date of birth: _____ Age: ____
Gender: ____Male ____Female
Home address: _____
City: _____ State: _____ Zip Code: _____
Parent/Guardian 1: _____
Parent/Guardian 2: _____
Pediatrician: _____
Primary Language: _____

1. Please indicate any concerns you have for your child in the following area(s):

- ☐ articulation
- ☐ receptive language
- ☐ expressive language
- ☐ social skills
- ☐ auditory processing
- ☐ stuttering / fluency
- ☐ mouth breathing
- ☐ not talking yet
- ☐ limited number of words
- ☐ not putting words together
- ☐ basic concepts
- ☐ feeding / swallowing difficulties
- ☐ following simple directions
- ☐ orofacial myofunctional disorder
- ☐ poor memory
- ☐ reading comprehension
- ☐ voice quality
- ☐ word finding
- ☐ attention/focus
- ☐ behavior
- ☐ referred by medical / dental professional

2. When did you first notice the problem(s) indicated above?

3. Is your child currently or previously received any speech therapy services? If yes, please explain.

Pregnancy & Delivery:

Did the child's mother have any illnesses or complications during pregnancy or delivery? Please describe:

_____

Was your child premature? YES NO
Born at how many weeks gestation: _____ Birth Weight: _____
Did your child require any medical procedures before, during, or after birth? Please describe:

_____

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Developmental History:
Please indicate at what **age** each major milestone was reached:
Sitting up by self: _____ Crawling: _____ Walking: _____
First word: _____ Two words together: _____
What was their first word? _____What was their first phrase? _____

When did you first become concerned about your child's development?
_____

Feeding:
Did your child have any feeding problems as an infant? Please describe:
_____
Was your child bottle fed or breast fed and for how long? _____
Did your child have any colic or reflux issues? _____
Describe your child's current eating habits and typical intake:
_____

Medical History:
Please describe illnesses, hospitalizations, or surgeries that your child has had and when they occurred:
_____
Is there a family history of speech-language or other developmental delays?
_____
Has your child had a neuropsychological evaluation? YES NO
If yes, date of most recent evaluation: _____
Name of neuropsychologist: _____

Social History & Living Situation:
Please describe your child's living situation (and any recent changes):
_____
Siblings' names and ages:
_____

Educational History:
Grade: _____ Name of school: _____
What kind of classroom (e.g., regular ed, special ed, life skills, etc.): _____
Does your child have an IEP? YES NO
What services does your child receive at school through the IEP? _____

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Hearing & Vision:

Has your child had his/her hearing tested? YES NO

When? _____ What were the results? _____

Has your child had any ear infections?: _____

Did your child ever have tubes placed in his/her ears? When? _____

Does your wear hearing aids? For what condition? _____

Personal Information:

Please describe your child's personality:

How do you handle discipline issues at home?

Does your child have tantrums? YES NO

How often? _____

What games, activities, toys does your child enjoy?

Describe how your child interacts with other children: