COLUMBUS SPEECH & HEARING CENTER
We Improve Communication for Life

Speech and Language Questionnaire for Children: Ages 0-3

Child's Name: _____ Date of Birth: _____

Name of Person Completing this Form: _____

Relationship to Child: _____ Today's Date: _____

Whom should we thank for referring you to the Columbus Speech & Hearing Center?

_____

1. GENERAL INFORMATION

What is it about your child's speech and language development which concerns you?

_____

_____

_____

When was it first noticed?

_____

Describe your child's communication skills:

_____

_____

_____

Does your child become impatient or frustrated when not understood?

_____

Describe any changes in your child's communication skills within the past three months:

_____

_____

Describe your child's overall strengths and weaknesses:

_____

_____

_____

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2. MEDICAL HISTORY

History of Pregnancy: Were there any problems with the pregnancy with this child (Rh incompatibility, toxemia, drug/alcohol abuse, exposure to infectious diseases, etc.)?

_____

_____

Labor and Delivery History

Full Term: YES ☐ No ☐ If no, how early? _____

Complications (meconium aspiration, forceps delivery, fetal distress, etc):

_____

Child's Birth Weight: _____ lbs _____ oz. Apgar Scores: _____

Problems of Newborn Period	Comments	Present	Absent
Breathing problems		☐	☐
Infections		☐	☐
Feeding difficulties: *(poor suck, spitting up or vomiting, choking)*		☐	☐
Seizures		☐	☐
Deformities		☐	☐

In regular or special care nursery? _____

Length of stay in nursery? _____

Medication for infant (if known):

_____

Disposition/temperament (colic, sleep patterns, acceptance of being held):

_____

Medical History of Child After 10 Days of Age

Hospitalizations or Operations:

Date Hospital Reason

_____

_____

_____

Medications currently taken:

_____

_____

Childhood Diseases: (Please check all that apply.)

☐ Measles ☐ Mumps ☐ Roseola
☐ Chicken Pox ☐ Scarlet Fever ☐ Whooping Cough

Any unusual problems: _____

Other Childhood Problems: (Please check all that apply.)

☐ Allergies ☐ Asthma ☐ Feeding Problems
☐ Growth/Weight Problems ☐ Headaches/Dizziness ☐ Fevers
☐ Meningitis/Encephalitis ☐ Persistent Drooling ☐ Persistent Vomiting
☐ Seizures ☐ Pneumonia ☐ Flu Recurrent Ear Infections/Tubes
☐ Recurrent Colds ☐ Sinusitis ☐ Urine/Bowel Problems
☐ Vision Problems ☐ Other: _____

Does your child have a diagnosed medical condition that you feel is contributing to their speech problems? ☐ YES ☐ NO

The medical condition: _____

Please bring to the evaluation any reports or other information you may have that is related to this.

3. DEVELOPMENTAL HISTORY

The approximate age your child achieved the following developmental milestones:

Age	Milestone	Age	Milestone	Age	Milestone
	Sat alone		Crawled		Said First Words
	Grasped crayon/pencil		Hand preference		Walked
	Toilet trained				

Speech-Language Development

Did/does your child:

☐ coo, babble, vocal play ☐ imitate sounds, words or phrases
☐ play peek-a-boo, pat-a-cake ☐ understand what you are saying
☐ respond appropriately to yes/no questions ☐ use single words by 12 to 18 months
☐ imitate gestures (e.g., wave bye-bye, "so-big") ☐ use two-word utterances by 24 to 30 months
☐ follow simple directions (e.g.,"shut the door")
☐ imitate oral movements (kissing, blowing, sticking out tongue, licking lips)
☐ retrieve/point to common objects (e.g., ball, cup, body parts) upon request

How does your child currently communicate?

☐ body language (pointing, gesturing, facial expressions, pulling, tugging)
☐ sounds (vowels, grunting)
☐ single words (e.g. "shoe," "doggie")
☐ two-word sentences (e.g. "more juice")
☐ three to four-word sentences (e.g. "I want ball")
☐ sentences longer than four words
☐ Other: _____

Feeding and Oral Habits

☐ My child can drink from an open cup

☐ My child usually drinks from a:

◯ bottle ◯ sippy cup ◯ drink box/cup with straw ◯ open cup

Do you have any concerns about your child's eating, drinking, oral habits?

☐ difficult to feed
☐ chews on clothes
☐ grinds teeth
☐ stuffs food in mouth
☐ eats a limited variety of foods
☐ drools
☐ mouths toys and/or other non-food objects
☐ sucks thumb, fingers, or uses pacifier
☐ gags
☐ chokes on foods or liquids
☐ tolerates brushing teeth

Please describe other concerns, if any regarding your child's eating/oral habits:

_____

_____

Indicate any other evaluation or therapy your child has received:

Service	**Provider**
Speech	
Hearing	
Physical Therapy	
Occupational Therapy	
Neurological	
Psychological	
Other	

Has your child ever received an evaluation through Help Me Grow or your public school system?

☐ YES ☐ NO If yes, please provide a copy of the evaluation to us.

4. FAMILY INFORMATION

Parent/Caregiver #1

Name _____

Relationship to child (mother/father/grandparent/foster parent/other) _____

◯ Lives in the home ◯ Lives outside the home ◯ Shared Parenting

Parent/Caregiver #2

Name _____

Relationship to child (mother/father/grandparent/foster parent/other) _____

◯ Lives in the home ◯ Lives outside the home ◯ Shared Parenting

Other Adult(s) living in the home

Name _____

Relationship to child (step parent/foster parent/grandparent/aunt/uncle/family friend/other)

_____

First names and ages of other children in the family/in the home:

_____

_____

Any family history of the following:

- ☐ Speech/language delays
- ☐ Hearing loss
- ☐ ADHD
- ☐ Autism/PDD
- ☐ Developmental Delays
- ☐ Learning Disabilities
- ☐ Dyslexia
- ☐ Movement Disorder

Family pattern of hand dominance: _____

What languages are spoken in the home? _____

5. OTHER

Does your child interact with other children on a regular basis? (siblings, daycare, preschool, babysitter, playgroup)

_____

_____

Behavior patterns: (check all that apply)

- ☐ Cooperative; gets along with others (children & adults)
- ☐ Attentive
- ☐ Willingly tries new activities
- ☐ Can play alone for reasonable length of time
- ☐ Separation difficulties
- ☐ Easily frustrated/agitated
- ☐ Imitates actions/gestures/speech
- ☐ Self-abusive behavior (please list) _____
- ☐ Restless
- ☐ Poor eye contact
- ☐ Easily distracted/short attention
- ☐ Destructive/aggressive
- ☐ Withdrawn
- ☐ Stubborn
- ☐ Interacts well with children/adults

_____

☐ Inappropriate behaviors: (please list) _____

_____

Other concerns or information you would like us to know about your child or family:

_____