Speech and Language Questionnaire for Children: Ages 4+

Child's Name: _____ Date of Birth: _____

Name of Person Completing this form: _____

Relationship to Child: _____ Date Today: _____

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

_____

1. GENERAL INFORMATION

What are your reasons for scheduling this appointment?

_____

_____

_____

When was the difficulty first noticed?

_____

_____

_____

Describe your child's communication skills:

_____

_____

_____

Is your child aware of and/or frustrated by any speech-language difficulties?

_____

_____

_____

What are the things you have done to try to help?

_____

_____

_____

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2. MEDICAL HISTORY

Were there any problems with the pregnancy with this child (Rh incompatibility, toxemia, drug/alcohol abuse, etc)?

_____

_____

_____

Were there any problems relating to this child's birth or delivery (prematurity, time in incubator or NICU, breathing problems, low birth weight)?

_____

_____

_____

Please tell the approximate age your child achieved the following developmental milestones:

	Sat alone		Crawled		Said first words
	Grasped crayon/pencil		Hand Preference		Walked
	Toilet trained				

Does your child:

Choke on food or liquids ☐ YES ☐ NO

Currently mouth toys/objects ☐ YES ☐ NO

Tolerate having his/her teeth brushed ☐ YES ☐ NO

Are you working with an orthodontist? ☐ YES ☐ NO

Has your child had any of the following? (Please check all that apply.)

☐ Measles	☐ Tonsillitis	☐ Frequent colds
☐ Chickenpox	☐ Tonsillectomy	☐ Ear infections
☐ Mumps	☐ Adenoidectomy	☐ Tubes in ears
☐ Scarlet fever	☐ Allergies	☐ Flu
☐ Meningitis	☐ Sinusitis	☐ Difficulty breathing
☐ Encephalitis	☐ Vision problems	☐ Difficulty sleeping
☐ Seizures	☐ High fevers	☐ Thumb/finger sucking habits

Is your child on daily medication? Please list.

Drug Name Condition it is taken for

_____

_____

_____

Hospitalizations or Operations:

Date Hospital Reason

_____

_____

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. SPEECH AND LANGUAGE DEVELOPMENT (Check all that apply.)

Did/Does your child:

☐ Repeat sounds/words or phrases over and over?

☐ Use single word together at 24 to 30 months?

☐ Understand what you are saying?

☐ Retrieve/point to common objects upon request (ball, cup, shoe)?

☐ Follow simple directions (e.g. "Shut the door.")?

☐ Respond correctly to yes/no questions?

☐ Respond correctly to who/what/where/when/why questions?

Your child currently communicates using:

☐ Body language (pulling, tugging, gestures)
☐ Sounds (vowels, grunting)
☐ Words (e.g. "shoe, doggy, up")
☐ 2 to 4- word sentences
☐ Sentences longer than four words
☐ Other: _____

Indicate any other evaluation or therapy your child has received:

Service	**Provider**
Speech	
Hearing	
Physical Therapy	
Occupational Therapy	
Neurological	
Psychological	
Help Me Grow	
Other	

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

Behavioral characteristics: (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/impulsive
- ☐ Stubborn
- ☐ Restless
- ☐ Poor eye contact
- ☐ Easily distracted/short attention
- ☐ Destructive/aggressive
- ☐ Withdrawn
- ☐ Inappropriate behavior
- ☐ Self-abusive behavior

My child's favorite activities are:

_____

_____

_____

Other concerns/information you would like us to know about your child and/or family.

_____

_____

_____

6. PLEASE ANSWER IF YOUR CHILD IS IN SCHOOL

Name of school and grade in school: _____

Has your child repeated a grade? _____

What are your child's strengths and/or best subjects?

_____

_____

_____

Is your child having difficulty with any subject? If yes, what help is your child already receiving?

_____

_____

_____

Has your child received a Multifactored Evaluation at school?
☐ YES ☐ NO If yes, please provide a copy of the report to us.

Does your child have an IEP through school?
☐ YES ☐ NO If yes, please provide a copy of the IEP to us.

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