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 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?

_____

_____

_____

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

Please list any allergies your child has: _____

Please list any medication that is used to counteract the effects of all the allergies:

_____

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 ❑ Developmental Delays

❑ Hearing loss ❑ Learning Disabilities

❑ ADHD ❑ Dyslexia

❑ Autism/PDD ❑ 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 *Please provide a copy of the report to us.* ❑ NO

Does your child have an IEP through school?

❑ YES *Please provide a copy of the IEP to us.* ❑ NO