



COLUMBUS
SPEECH & HEARING
EST. 1923

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:

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**

Problems of Newborn Period	Comments	Present	Absent
Breathing problems			
Infections			
Feeding difficulties: <i>(poor suck, spitting up or vomiting, choking)</i>			
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: .

.....bottlesippy cupdrink box/cup with strawopen 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) _____SSSSSSSSS

.....@ives in the homeLives outside the homeShared Parenting

Parent/Caregiver #2

Name _____

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

.....@ives in the homeLives outside the homeShared 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:

- | | |
|---|--|
| <input type="checkbox"/> Speech/language delays | <input type="checkbox"/> Developmental Delays |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Dyslexia |
| <input type="checkbox"/> Autism/PDD | <input type="checkbox"/> 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)

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 Withdrawn |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

Inappropriate behaviors: (please list) _____

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