COLUMBUS SPEECH & HEARING
EST.1923

Speech and Language Questionnaire for Children: 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?
_____
_____
_____

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

_____

_____

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	

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? _____

4. 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.

_____

_____

_____

5. 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. _____