



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? _____

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 or frustrated by any speech-language difficulties?

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



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 foods or liquids Yes No
- Currently mouth toys/objects Yes No
- Tolerate having their 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.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Encephalitis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> High fevers | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Tubes in ears | <input type="checkbox"/> Flu |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> 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

SPEECH AND LANGUAGE DEVELOPMENT (CHECK ALL THAT APPLY.)

Did/does your child:

- Repeat sounds/words or phrases over and over?
- Use single words together at 24 to 30 months?
- Understand what you are saying?
- Retrieve/point to common objects upon request (e.g., ball, cup, shoe)?
- Follow simple directions (e.g., "shut the door")?
- Respond appropriately to yes/no questions?
- Respond correctly to who/what/where/when/why questions?

Your child currently communicates using:

- Body language (pulling, tugging, gestures)
- Words (e.g., "shoe, doggie, up")
- Sentences longer than four words
- Sounds (vowels, grunting)
- Two- to four-word sentences
- 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 (mother/father/grandparent/foster parent/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"/> Hearing loss |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Autism/PDD |
| <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Learning disabilities |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Movement disorder |

Family pattern of hand dominance:

What languages are spoken in the home?

OTHER

Behavioral Characteristics: (Check all that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Cooperative; gets along with others (children & adults) | <input type="checkbox"/> Attentive |
| <input type="checkbox"/> Willingly tries new activities | <input type="checkbox"/> Can play alone for a reasonable length of time |
| <input type="checkbox"/> Separation difficulties | <input type="checkbox"/> Easily frustrated/impulsive |
| <input type="checkbox"/> Stubborn | <input type="checkbox"/> Restless |
| <input type="checkbox"/> Poor eye contact | <input type="checkbox"/> Easily distracted/short attention span |
| <input type="checkbox"/> Destructive/aggressive | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Inappropriate behavior | <input type="checkbox"/> Self-abusive behavior |

My child's favorite activities are:

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

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 best subjects?

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

Has your child received a Multifactorial 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.
