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: _____

Whom should we thank for referring you to Columbus Speech & Hearing?: _____

GENERAL INFORMATION

What is it about your child's speech and language development that 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:

_____

_____

_____

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 During Newborn Period	Comments	Present	Absent
Breathing Problems			
Infections			
Feeding Difficulties *(poor suck, spitting up or vomiting, choking)*			
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 contributes 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 condition.

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

☐ Play peek-a-boo, pat-a-cake

☐ Respond appropriately to yes/no questions

☐ Imitate gestures (e.g., wave bye-bye, “so-big”)

☐ Follow simple directions (e.g., “shut the door”)

☐ Imitate oral movements (e.g., kissing, blowing, sticking out tongue, licking lips)

☐ Retrieve/point to common objects (e.g., ball, cup, body parts) upon request

☐ Imitate sounds, words or phrases

☐ Understand what you are saying

☐ Use single words by 12 to 18 months

☐ Use two-word utterances by 24 to 30 months

How does your child currently communicate?

☐ Body language (e.g., pointing, gesturing, facial expressions, pulling, tugging)

☐ Sounds (e.g., vowels, grunting)

☐ Single words (e.g., “shoe,” “doggie”)

☐ Two-word sentences (e.g., “more juice”)

☐ Three- or 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:

O Bottle O Sippy cup O Drink box/cup with straw O Open cup

Do you have any concerns about your child's eating, drinking or oral habits?

☐ Difficult to feed
☐ Chews on clothes
☐ Grinds teeth
☐ Stuffs food in mouth
☐ Eats a limited variety of foods
☐ Drools
☐ Mouths toys 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:

_____

_____

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.

FAMILY INFORMATION

Parent/Caregiver #1

Name _____

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

O Lives in the home O Lives outside the home O Shared parenting

Parent/Caregiver #2

Name _____

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

O Lives in the home O Lives outside the home O 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:

Behavior patterns: (Check all that apply.)

- ☐ Cooperative; gets along with others (children & adults)
- ☐ Attentive
- ☐ Willingly tries new activities
- ☐ Can play alone for a reasonable length of time
- ☐ Separation difficulties
- ☐ Easily frustrated/agitated
- ☐ Imitates actions/gestures/speech

Self-abusive behavior (Please list.)

- ☐ Restless
- ☐ Poor eye contact
- ☐ Easily distracted/short attention span
- ☐ Destructive/aggressive
- ☐ Withdrawn
- ☐ Stubborn
- ☐ Interacts well with children/adults

Inappropriate behaviors: _____

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