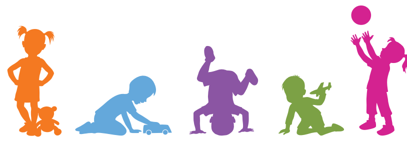

Speech-Language and Learning Parent Questionnaire

Children birth - 12 months

General Information

today's date: ____________________

child's name: ____________________

date of birth: ____________________

address: ____________________

gender: ☐ male ☐ female

____

parent name: ____________________

email: ____________________

occupation: ____________________

phone (h): __________ phone (c): __________

parent name: ____________________

email: ____________________

occupation: ____________________

phone (h): __________ phone (c): __________

names and ages of those living in the home: __________

primary language spoken at home: ____________________

____

pediatrician: ____________________

referred by: ____________________

pediatrician phone number: ____________________

1. Indicate any concerns you have for your child in the following area(s):

☐ sleeping ☐ attention ☐ behavior

☐ feeding ☐ snoring/noisy night breathing ☐ mouth breathing

2. When did you first notice the problem(s) indicated above?

3. Does anyone in your family history have a speech, language, hearing or learning problem that you are aware of?

☐ Yes ☐ No

If yes, please describe:

Kids Therapy Made Simple
822 S. Robertson Blvd., Suite #202 • Los Angeles, CA • 90035
web: www.kidstms.com • phone: 310.365.0500 • email: info@kidstms.com

Health and Developmental History

4. Did you have a typical pregnancy? ☐ Yes ☐ No Length of Pregnancy: ________________

Please list any complications:

5. Medications used during pregnancy:

6. Describe your child's delivery and birth:

☐ typical ☐ spontaneous ☐ induced ☐ Cesarean ☐ breech ☐ unusually long labor

Please list any complications:

7. Duration of labor: ______ hours

8. Medication used during labor:

9. What was your child's birth weight? ______________ APGAR score: ______________

10. What was your child's condition at birth?

☐ typical ☐ birth injury/defect ☐ jaundiced ☐ breathing problem ☐ low birth weight

☐ other: ______________

11. Does your child have a history of any of the following: (check all that apply)

☐ drooling ☐ ear tubes ☐ intubation / ventilator

☐ chronic ear infections ☐ surgery ☐ hospitalization

☐ allergies ☐ chronic or severe illness ☐ seizures

☐ asthma ☐ high or prolonged fevers ☐ head injury

☐ hearing loss ☐ reflux ☐ serious accident

Please explain any of the above as needed.

12. Has your child ever been hospitalized? How long?

13. List any medication(s) your child is currently taking:

14. Has your child received all of the vaccinations recommended by your pediatrician? ☐ yes ☐ no

15. Has your child ever had a hearing evaluation?

☐ Yes ☐ No

If yes, list dates and results:

16. Does your child have a history of feeding problems? ☐ Yes ☐ No

If yes, check all that apply:

☐ choking / coughing ☐ difficulty biting ☐ gagging / vomiting

☐ nursing difficulties ☐ difficulty chewing ☐ difficulty swallowing

Please describe:

17. Does your child have a history of trouble sleeping through the night?

☐ Yes ☐ No

18. Is your child a messy or picky eater?

☐ Yes ☐ No

Please list favorite foods:

Please list food sensitivities:

19. At what age did your child attain these developmental milestones?

Sitting:______________________ First Words:______________________

Crawling:______________________ Walking:______________________

Sensory and Motor

20. Does (or did) your child have any difficulty walking, running, sitting or with any large motor skills?

☐ Yes ☐ No

If yes, please describe:

21. Does (or did) your child have low body tone?

☐ Yes ☐ No

22. Is (or was) your child sensitive to certain textures of food or clothing?

☐ Yes ☐ No

If yes, please describe:

23. Does your child dislike having substances on his/her hands such as glue or dirt?

☐ Yes ☐ No

24. Is your child oversensitive to being touched or dislikes being touched?

☐ Yes ☐ No

If yes, please describe:

25. Check all that apply regarding your child, if any.

☐ dislikes washing his/her hair or face
☐ dislikes haircuts
☐ spends too little time or too much time brushing his/her teeth
☐ does not demonstrate caution
☐ puts things in his/her mouth besides food
☐ chews on his/her clothes

Behavior

26. Does your child typically display any of the following behaviors? (Check all that apply)

☐ reduced or lack of interaction with others
☐ tantrums
☐ passive in interactions
☐ very active
☐ under-active
☐ inattentive
☐ refuses to perform tasks
☐ difficulty staying on task
☐ difficulty finishing tasks
☐ sensitive
☐ angry/acting out behavior
☐ frustrated
☐ shy

Other Information

27. Who does your child live with? (Check all that apply)

- ☐ both parents
- ☐ mother only
- ☐ father only
- ☐ parent & stepparent
- ☐ grandparents
- ☐ foster parents
- ☐ Other ____________________________________

28. Are languages other than English spoken in the home?

☐ Yes ☐ No

If yes, please list:

29. Has your child been evaluated by any other professional? (Check all that apply)

- ☐ Speech-Language Pathologist
- ☐ Occupational Therapist (OT)
- ☐ Physical Therapist (PT)
- ☐ Developmental Pediatrician
- ☐ Psychologist/Psychiatrist
- ☐ Educator/Teacher
- ☐ Neurologist
- ☐ Physician
- ☐ Geneticist
- ☐ Other ______________________________

30. Does your child have a diagnosis from any of the above professionals?

☐ Yes ☐ No

If yes, please list date, professional and diagnosis for each:

31. Has your child had previous Speech-Language Therapy, Occupational Therapy or Physical Therapy?

☐ Yes ☐ No

If yes, please describe the goals and outcome of therapy:

32. What other concerns do you have about your child?

33. What do you consider to be your child's greatest strength?

34. What do you hope to gain from this evaluation?

35. Is there anything else you would like us to know about your child?

Thank You!