kids therapy made simple

Speech-Language and Learning Parent Questionnaire

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

- ☐ articulation
- ☐ receptive language
- ☐ expressive language
- ☐ social skills
- ☐ auditory processing
- ☐ stuttering / fluency
- ☐ mouth breathing
- ☐ not talking yet
- ☐ limited number of words
- ☐ not putting words together
- ☐ basic concepts
- ☐ feeding / swallowing difficulties
- ☐ following simple directions
- ☐ orofacial myofunctional disorder
- ☐ poor memory
- ☐ reading comprehension
- ☐ voice quality
- ☐ word finding
- ☐ attention/focus
- ☐ behavior
- ☐ referred by medical / dental professional

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

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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:

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: _____ hrs.

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:_____

Toilet Training:_____ First Sentences:_____

Voice and Fluency

20. Is your child's voice clear? ☐ Yes ☐ No

If no, please describe:

21. Describe your child's voice: (check all that apply, if any)

- ☐ nasal
- ☐ denasal (sounds like s/he has a cold)
- ☐ loud
- ☐ soft
- ☐ high-pitched
- ☐ low-pitched
- ☐ monotone
- ☐ breathy
- ☐ hoarse

22. Does your child talk smoothly without repeating sounds or words? ☐ Yes ☐ No

If no, does s/he have trouble getting words out? ☐ Yes ☐ No

If yes, please describe:

Auditory Processing and Learning

23. Does your child have difficulty with any of the following? (check all that apply)

- ☐ memory tasks
- ☐ comprehension
- ☐ word retrieval
- ☐ hearing difficulties
- ☐ listening with background noise
- ☐ reading difficulties
- ☐ spelling / writing difficulties
- ☐ phonologic / phonemic difficulties
- ☐ learning difficulties
- ☐ remembering and following multi-step directions
- ☐ putting thoughts together
- ☐ difficulty learning or using new vocabulary
- ☐ auditory attention
- ☐ academic under-achievement
- ☐ hypersensitivity to loud sounds
- ☐ word-finding difficulties
- ☐ auditory distractibility
- ☐ organization and planning

24. Does your child receive any services at school (IEP or 504 plan) or outside help?

☐ Yes ☐ No

If yes, please list all:

25. Can your child retell a simple story in sequence?

☐ Yes ☐ No

26. Can your child identify steps to complete a simple task? (e.g. brushing teeth, setting the table)

☐ Yes ☐ No

27. Does your child appear to attend to your face when listening?

☐ Yes ☐ No

28. Does your child appear to become easily distracted when listening?

☐ Yes ☐ No

29. Does your child appear to be confused with listening?

☐ Yes ☐ No

30. Does your child appear to be particularly uncomfortable in noise (as compared to same aged peers)?

☐ Yes ☐ No

Sensory and Motor

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

☐ Yes ☐ No

If yes, please describe:

32. Does (or did) your child tippy-toe walk?

☐ Yes ☐ No

33. Is (or was) your child clumsy or does s/he fall easily?

☐ Yes ☐ No

34. Does (or did) your child have difficulty with fine motor skills such as stacking, cutting and handwriting?

☐ Yes ☐ No

If yes, please describe:

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

☐ Yes ☐ No

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

☐ Yes ☐ No

If yes, please describe:

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

☐ Yes ☐ No

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

☐ Yes ☐ No

If yes, please describe:

39. 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

40. 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

41. Does your child have any of the following health problems?

- ☐ snoring
- ☐ noisy breathing at night
- ☐ restless sleep
- ☐ daytime tiredness
- ☐ difficulty concentrating
- ☐ bed-wetting
- ☐ open-mouth breathing
- ☐ difficulty breathing through nose
- ☐ ear, nose, throat infections
- ☐ allergies / asthma
- ☐ often sick with colds / infections
- ☐ developmental delays
- ☐ ADHD
- ☐ Autism Spectrum Disorder
- ☐ sensory sensitivities
- ☐ cleft lip / palate
- ☐ hearing / vision difficulties
- ☐ chronic stutter
- ☐ lisp
- ☐ other: _____

42. Please answer Yes or No to the following questions. If you are unsure just leave the answer blank. Any additional information you can provide is appreciated.

Does your child go to bed unwillingly?	☐ Yes	☐ No	_____
Does your child express fear or worries before going to bed?	☐ Yes	☐ No	_____
Does your child complain about difficulties falling asleep at night?	☐ Yes	☐ No	_____
Is your child a restless sleeper?	☐ Yes	☐ No	_____
Does your child wake up at night?	☐ Yes	☐ No	_____
Does your child get up to go to the bathroom at night?	☐ Yes	☐ No	_____
Is your child primarily a mouth-breather?	☐ Yes	☐ No	_____
Does your child have nightmares?	☐ Yes	☐ No	_____
Does your child have a problem with bed-wetting?	☐ Yes	☐ No	_____
Does your child stop breathing during sleep?	☐ Yes	☐ No	_____
Does your child sweat more than usual during sleep?	☐ Yes	☐ No	_____
Does your child have problems with anxiety or behavioral issues?	☐ Yes	☐ No	_____
Does your child have difficulty breathing during sleep?	☐ Yes	☐ No	_____
Is your child sleepy during the day?	☐ Yes	☐ No	_____
Does your child complain about tiredness / sleepiness?	☐ Yes	☐ No	_____
Does your child chew with their mouth open / messy eater?	☐ Yes	☐ No	_____
Does your child chew or bite on a pencil, hair, nail, etc?	☐ Yes	☐ No	_____

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

- ☐ both parents
- ☐ mother only
- ☐ father only
- ☐ parent & stepparent
- ☐ grandparents
- ☐ foster Parents
- ☐ other _____

44. What languages are spoken in the home?

☐ English ☐ Spanish ☐ Hebrew ☐ Farsi ☐ Other_____

45. 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_____

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

☐ Yes ☐ No

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

47. 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:

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

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

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

Thank You!