Date: _____

My Speechee
Parent Questionnaire

Thank you so much for taking the time to carefully fill out this form!

General Information:

Child's Name: _____ Birthdate: _____

Age: _____ Parent/Guardian(s) Name(s):_____

Siblings & Ages:_____

Address: _____

_____

Email: _____ Home #:_____

Work #:_____ Cell #:_____

Parent(s) Occupations(s): _____

Are there other adults in the home? If so, whom: _____

Have other siblings or family members experienced speech/language difficulties? Please describe: _____

What language(s) is/are spoken in the home?_____

In case of emergency, notify (other than the adult coming to the sessions):

_____

Phone: _____ Physician: _____

Dentist: _____ Orthodontist: _____

Other Therapist: _____ Other Doctor: _____

Referred by: _____

Statement of Problem:

Describe your child's speech/language/communication problem:_____

_____

_____

When was the problem first noticed?:_____

Has problem changed/evolved? Please describe

_____

_____

What strategies have been used at home that seem to help: _____

_____

What professional services has your child received & when: _____

_____

If testing has been done, what skills were assessed? _____

Speech, Language and Hearing History:

As an infant, did your child babble and play with sounds? _____

When did your child speak his/her first word? _____

When did s/he begin use to use 2-word phrases? _____

Does s/he use speech Always _____ Occasionally _____ Never _____

Does s/he prefer to use gestures? If so, give examples: _____

Does his/her speech include:

Sentences ☐ Phrases ☐ 1-2 words ☐ Sounds ☐

Examples: _____

How well can your child be understood by parents (use percentage): _____

by siblings _____ by friends or playmates _____ by strangers _____

Describe your child's auditory behavior (hearing speech and environmental sounds, following directions , etc.): _____

_____

Has speech/language been tested in the last 6 months? By whom?

_____

Has hearing been tested in the past year? By whom? _____

_____

Has vision been tested in the past year? By whom? _____

_____

Social/Behavior:

Does your child:

Make eye contact ☐ Respond on topic ☐ Interrupt appropriately ☐
Stay on topic ☐ Tell you the names of things ☐
Tell you how things are used ☐ Describe things and actions ☐
Ask for information ☐ Give information ☐ Make requests ☐
Apologize ☐ Protest ☐ Show humor ☐ Solve problems verbally ☐
Greet people ☐

Is your child:

Competitive ☐ Sensitive to criticism ☐ Perfectionist ☐
Mature for age ☐ Overly sensitive to touch ☐
Overly sensitive to sound ☐ Other:_____
What are your child's favorite play activities? _____

_____

Does your child play alone or with other children? _____
How does s/he get along with other children? _____
How does s/he get along with adults? _____
Is it difficult to discipline your child? _____
How would you describe your child? _____

Birth and Developmental Information:

Age of parents at child's birth: Mother_____ Father _____ Is this an adopted child? _____ Child's age at adoption _____

Mother's health during pregnancy:

_____

Full term child?_____

If no, # of weeks gestation at birth: _____

Birth weight? _____

Describe delivery: _____

Birth injury?_____ Jaundiced? _____

Oxygen required?_____ Heart murmur? _____

Nursing difficulty? _____

Child's health during first several months:

_____

Any significant childhood illnesses, injuries, or abnormalities?

_____

Indicate ages at which your child accomplished the following:

Sat alone: _____ Walked alone: _____ Dressed self: _____

Stood alone: _____ Bowel trained: _____ Crawled: _____

Bladder trained: _____

Was child's rate of growth seemingly normal? _____

Was normal development interrupted by anything?

_____

Does your child have difficulty with gross or fine motor tasks? _____

Feeding History:

Was child breast-fed or bottle-fed? _____

If breast-fed, how long? _____

If bottle-fed, how long? _____

Were there early feeding problems such as colic, special formula, or difficulty making the transition to table food_____

Does s/he drink more than one glass of liquid with meals? _____

Does s/he appear to wash down food? _____

Is s/he a fast or slow eater? _____

Does s/he chew food adequately? _____

Does s/he belch excessively? _____

Does s/he have frequent digestive problems? _____

Does s/he choke easily? _____

Does s/he resist foods that are difficult to chew? _____

Does s/he eat a variety of foods, textures, temperatures, flavors? _____

Is s/he on a special diet? Describe: _____

Medical History:

Age/Severity

Tonsillitis: _____

Tonsillectomy: _____

Adenoidectomy: _____

Lingual Frenectomy: _____

Middle Ear Infections: _____

Earaches:_____

Ear Surgery: _____

Hearing Loss: _____

Heart Problems: _____

High Fevers/Measles: _____

Mumps: _____

Pneumonia: _____

Frequent Colds: _____

Upper Respiratory Infections: _____

Snoring: _____

Allergies: _____

Asthma: _____

Sinus Problems: _____

Headaches:_____

Seizures:_____

Head Injury: _____

Loss of Consciousness: _____

GERD (Acid Reflux): _____

Visual difficulty: _____

Is your child currently under a physician's care? For: _____

Is your child taking any medications? _____

Other medical conditions not mentioned: _____

Is there smoking in the home? _____

Is general health good? _____

Other injuries or surgeries?_____

Dental History:

Has your child ever sucked thumb/fingers: _____ Until what age: _____ Did your child use a pacifier: _____ Until what age: _____

Were baby teeth normal? _____

Were baby teeth lost at normal ages?_____

Were baby teeth lost to accident or injury?

_____

Does your child have difficulty chewing, eating, and/or swallowing food: ___

Does your child often have headaches: _____

Any severe facial injuries: _____

Have permanent teeth been injured/chipped/lost: _____

If your child has seen an orthodontist, what has been done so far?

_____

Any orthodontic appliances in currently in place? _____

Are adjustments still being made? _____

When will appliance come off? _____

What does the orthodontist plan to do in the future? When? _____

Educational Information:

School: _____Grade: _____
Address: _____ Teacher's Name:
_____

Does child excel in any subjects/areas?
_____

Does s/he struggle in any subjects/areas?_____

Does s/he read at grade level? _____

Does s/he enjoy reading? _____

Does s/he spell at grade level? _____

Does s/he enjoy writing? _____

How does your child feel about school and his/her teachers? _____
_____

Is/Has your child been in any special programs (Speech, Language, Reading, Special Ed., etc.): _____

If so, Teacher's/SLP's Name(s):
_____

Questions & Additional Information:

Are there specific questions you would like answered about your child?
_____

_____

_____

_____

_____

_____

_____

_____

Is there anything else about your child or your family that I should know

that might help me provide better service? _____

_____

_____

_____

_____