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Speech/Language Client Questionnaire

First Name: ____________________ Last Name________________________ DOB: ______________

History and Concerns

Previous speech therapy evaluations (circle one): Yes/No

If yes, where and when: ____

Other therapies to date (OT, PT, ST): ____

What is the reason you are seeking a speech/language evaluation?

____

____

Who noted the present concern? _______________________When? _______________________

Is your child aware of the noted concern(s): ____________________________________

Describe what it is like to have a conversation with your child:

____

____

____

Have there been any significant changes (at home, family, etc.) in the last six months? If so, what?

____

____

What percentage of the time is your child understood by others? (10%, 25%, 50%, 75%, etc.)

Parents	Siblings	Other Adults	Other children

Names and ages of siblings (if any): ______________________________

____

Are any of the following a concern for your child:

Express frustration when trying to communicate?	Yes	No
Has difficulty pronouncing certain sounds?	Yes	No
Has difficulty answering questions?	Yes	No
Has difficulty following directions?	Yes	No
Struggles to convey a clear message when speaking, even if words are easy to understand.	Yes	No
Gets stuck on or repeats words when talking?	Yes	No
Has difficulty with his/her voice, vocal quality or breathing?	Yes	No
Has a hard time making friends?	Yes	No
Has difficulty understanding and following social rules?	Yes	No

CURRENT GENERAL HEALTH

Does your child have a medical diagnosis(es)? ______________________________

Allergies? (Circle one) Yes/ No   If Yes, list: ______________________________

Any other serious or recurrent illnesses? ______________________________

____

Does your child wear glasses? (Circle one) Yes/ No

Do you have any concerns about your child's hearing? (Circle one) Yes/ No

If yes, please explain: ______________________________

When was the last time your child's hearing was screened? If so, where? ______________________________

Has your child had a history of earaches/ear infections? (Circle one) Yes/No

Ear Tubes? ________________________ Are they still in place? __________________________________

If chronic (more than 4 in 12 months), please provide frequency:

____

Any medical operations? Yes/No. If yes, please describe: _______________________________________

____

Any accidents/falls involving trauma to the head or concussions? ________ If so, when did they occur?

____

Any significant dental procedures? (Braces, retainer, oral expander, etc.)

____

Does your child have a history of cleft palate, cleft lip, etc.?

____

DEVELOPMENTAL HISTORY

Full Term (37+ weeks) _______ Premature ______ Weeks Early? ________________ Placed in the N.I.C.U.? (Circle one) Yes/No

Any complications or abnormalities during pregnancy, birth, or early development?

____

Use or exposure to alcohol, tobacco, drugs or medications during pregnancy:

____

FEEDING HISTORY

Any difficulties feeding currently? ___________ Historically? ___________ If so, explain:_____________

____

____

Concerns with: Swallowing: ______________Chewing: ______________ Drinking: ________________

Drooling: ________________ Orally Defensive: ________________

Is your child on a restrictive diet (i.e., gluten free, dairy free, etc.)?

____

____

Is your child OG, NG, or G-tube fed?

____

LANGUAGE DEVELOPMENT HISTORY

Please provide approximate age your child:

Babbled: ________ First words: _________ 1–2-word phrases: __________ Sentences: ___________

Which speech sounds (if any) are of concern? ____

Does your child communicate with more than 15 words/phrases? (Circle one) Yes/ No

If no, please provide list of words below: ____

____

____

Any speech or hearing difficulties in the immediate or extended family (explain)?

____

____

SOCIAL/EMOTIONAL HISTORY

Will your child play with? (Circle all that apply)

Friends Family Familiar Kids Unfamiliar kids other adults

Does your child have difficulty with: (circle all that apply)

Transitioning Paying attention. Loud Sounds Bright Lights Figurative Language

Maintaining a Conversation Telling Stories Understanding Stories Perseveration

Does your child: (circle all that apply)

Laugh/Smile Get Upset Easily Self Calm Recognizing Feelings Cry Appropriately

Is your child able to manage? (Circle all that apply)

Frustration/Conflict   Separation   Unfamiliar People   Responsibilities

Last minute Changes

Make wants/needs known? __________ How (words, gestures etc.)?

____

Does your child exhibit unusual behavior/s (explain)?

____

Does your child acclimate easily to change?

____

What are your child's interests and what motivates them?

____

____

Anything else you would like us to know? ________________________________

____