Clinician:

Evaluation Date:

PARENT QUESTIONNAIRE
SPEECH AND LANGUAGE EVALUATION

Child's Name: ____________________ DOB: ____________________

Today's Date: ____________________ Medical or Developmental Diagnoses: ____________________

School Diagnoses: ____________________ Language(s) Spoken at Home: ____________________

Caregiver's Name: ____________________ Relationship to Patient: ____________________

Caregiver's Name: ____________________ Relationship to Patient: ____________________

Brothers/Sisters:

Name: ____________________ Age: ____________________ Grade: ________

Name: ____________________ Age: ____________________ Grade: ________

Name: ____________________ Age: ____________________ Grade: ________

Who currently lives in the home? (including foster children and those living part time with family):

Who is your child's primary caregiver?

Primary Concerns:
Describe your child's speech problem: ______________________________ ______________________________ ______________________________ ______________________________
When did you notice your child's speech/language problem?

____

____

Does your child have family members with any of the following concerns:

Speech or Language	Yes	No	If yes, who? ________________________
Stuttering	Yes	No	If yes, who? ________________________
Hearing Loss	Yes	No	If yes, who? ________________________
Cleft Palate	Yes	No	If yes, who? ________________________
Autism Spectrum	Yes	No	If yes, who? ________________________
Developmental Delay	Yes	No	If yes, who? ________________________
Reading or Learning Disability	Yes	No	If yes, who? ________________________
ADHD	Yes	No	If yes, who? ________________________

Additional comments or concerns:

____

____

Health and Developmental History

Did you have a normal pregnancy? Yes No

If No, please list any problems: ____

Length of pregnancy:_______________ Gestational Age (weeks): _______________

Describe your child's delivery and birth:

Typical Spontaneous Induced Vaginal Head first

Feet first Cesarean Breech Unusually long labor

What was your child's birth weight? ____________________ APGAR Score: _____________

Were there any breathing or swallowing complications at birth? Yes No

If Yes, please explain: ____

Did your child require a NICU stay? Yes No

If Yes, please explain: ____

Was your child intubated? Yes No

If Yes, please explain: ____

Did your child require supplemental nutrition? Yes No

If Yes, please explain: ____

Was your child discharged home with supplemental feeds? Yes No

Please note any additional birth history information you think is relevant:

____

____

____

____

Does your child have a history of any of the following? (Check all that apply)

Drooling Ear Tubes Intubation/Ventilator

Ear Infection Surgery Hospitalization

Allergies Chronic or Severe Illness Seizures

Asthma High or Prolonged Fever Head Injury

Hearing Loss Reflux Serious Accidents

Neurological Condition Pneumonia or upper respiratory infections

Please explain any of the above as needed: ____

____

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

____

What is your child's current state of health? Excellent Good Fair Poor

Has your child ever had a hearing evaluation? Yes No

If yes, list date(s) and results:____

If impaired, what degree of loss? Please check. Mild moderate severe profound

uncertain uncertain as patient may hear yet not react

Is patient aided? Please check. No aid unilateral cochlear implant bilateral cochlear implant unilateral hearing aide bilateral hearing aid unknown device

other:___________________

Has your child ever had a vision evaluation? Yes No

If yes, list date(s) and results:____

Does your child wear glasses? Yes No

Check the options that best describe your child's breathing:

Normal (Breathing room air) Oxygen Needed Noisy Breathing

Asthma	Retractions	Supplemental Ventilation
Other: ______________________________		

Is your child followed by any medical professionals? Yes No

If yes, by whom? ______________________________

Has your child had any of the following procedures? (please check)

Video Fluoroscopic Swallow Study (VFSS)	Upper GI
Fiberoptic Endoscopic Evaluation of the Swallow (FEES)	MRI
Bronchoscope and Laryngoscope	CT Scan
Botox	X-Ray

Other: ______________________________

If Yes, what were the results?______________________________

____

Does your child have any durable medical equipment used at home? Yes No

If yes, list equipment:______________________________

Does your child have a history of feeding problems? If yes, check all that apply:

Choking   Difficulty Biting   Overstuffing Mouth   Poor Nursing

Difficulty Chewing   Difficulty Swallowing

Other: ______________________________

Is your child a messy, or picky eater? ______________________________

How would you describe your child's sleep patterns?

No concerns	waking at night	snoring	mouth breathing
other: ____			

At what age did your child attain these developmental milestones:

Rolled: ______________ Sat up: __________________ Stood: __________________

Crawled: _____________ Walked: __________________ Fed self: ___________________

Used cup: _____________ Dressed self: ________________ Toilet Training: ______________

Used single words: _________ Combined words: ____________ Engaged in conversation: _________

Gastroenterology/Feeding

Does your child have a history of reflux or vomiting? Yes No

If Yes, please explain: ____

Does your child have a history of constipation? Yes No

If Yes, please explain: ____

Does your child have a history of diarrhea? Yes No

If Yes, please explain: ____

Has your child demonstrated difficulty gaining or maintaining weight? Yes No

If Yes, please explain: ____

Has your child ever had an alternate means of nutrition? Yes No

If Yes, please explain: ____

Place a checkmark next to the feeding milestones your child has achieved:

None Breastfeeding Bottle Feeding Stage 1 baby food

Stage 2 baby food Dissolvable solids Finger foods Spoon

Fork Knife Straw Open cup Pours drink

Does/Did your child use a pacifier? Yes No

If Yes, what age did your child stop? ___________________________________

Describe how the weaning process from the breast and/or bottle went and why your child was weaned: ____

____

How did your child handle moving between the stages of feeding milestones? ___________________

____

____

Does your child cough or choke with feeding? Yes No If Yes, how often and when?____
Describe mealtime . Who is with the child, where does the child sit, what is the environment like, is special equipment used, etc.: ____ ____ ____ ____ ____
Describe your child's appetite:____ ____ ____
How long does a typical meal last: ____
How does your child respond when presented with a food item he or she does not like? _____________ ____ ____ ____
Tube Feedings: If your child is tube fed, please provide their feeding regimen for a whole day: ____________________ ____ ____

____

Describe where your child is tube fed and what activities are occurring at the same time: ____________

____

____

____

Describe your child's reactions to the tube feedings: ____

____

____

____

Speech and Language
Did your child babble? Yes No If yes, did he/she use a variety of sounds when babbling? Yes No
What were your child's first words? ____
Once your child started to use words, did he/she continue to add new words to his/her speaking vocabulary on a weekly basis? Yes No
Does your child have a history of using a word once or several times, and then never using it again? Yes No If yes, please give examples:____

Is your child reluctant to communicate or become frustrated when trying to speak? Yes No

If yes, please describe: ____

Is your child reluctant to imitate speech sounds or words? Yes No

If yes, does he/she refuse these types of tasks? Yes No

Does it seem that your child has more difficulty producing understandable speech on some days and not others or at certain times? Yes No

If yes, please explain any consistencies you may have noticed:

____

How would you describe your child's speech errors?

Consistent Change from word to word and/or day to day

Check the speech sounds your child currently uses:

VOWELS: Long: a e i o u Short: a e i o u

CONSONANTS: p b m w t d n f v k g

h s z sh ch j y l r th

Approximately how much of your child's speech do you understand?

Less than 25% 25% 50% 75% 100%

Can people outside the family understand your child's speech? Yes No

Is your child aware of his/her difficulties? Yes No Unsure

What does your child do when you do not understand? ____

How would you describe the melody and rhythm of your child's speech? (Check all that apply)

Smooth Slow Soft Loud Lacking in Intonation

Halting Fast Choppy Lacking in Pitch Changes

How does your child typically communicate with others? (Check all that apply)

Talking (whether understandable or not) Pointing Gestures Crying

Pulling/taking adult to what he/she wants Signs Pictures Facial Expressions

Voice Output Speech Device Other: ____

Does your child play and communicate well with his/her friends and family? Yes No

If no, please describe:____

Describe how your child interacts with other children: ____

____

Does your child seem to understand most of what you say & tell him/her to do? Yes No

Does your child have difficulty following directions? Yes No

If yes, please describe:____

How many words does your child now use?

0-20 20-50 100-150 150-200 200+

If you child uses phrases and sentences, how long are they on average?

2 words	3 words	4 words	5 words	Longer than 5 words

Does your child (check yes or no for each)	**Yes**	**No**
Ask questions to gain information……………………………………		
Understand vocabulary……………………………………………...		
Use age-appropriate vocabulary………………………………………		
Stay on subject in a conversation……………………………………..		
Take turns when talking to someone…………………………………		
Describe and explain…………………………………………….....		
Answer questions……………………………………………………..		
Have difficulty putting words together into a sentence……………..		
Leave words out of sentences………………………………………		
Use correct grammar such as plurals, verb tenses, pronouns…….		

Voice and Fluency
Is your child's voice clear? Yes No If no, please describe:____
Describe your child's voice. (Check all that apply) Nasal Monotone High-pitched Low-pitched Soft Loud Breathy Hoarse Denasal (sounds like he/she has a cold)

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

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

If yes, please describe: ____

Auditory Processing and Learning
Does your child attend daycare, mother's day out? Yes No If yes, how often: _______________________ where: ___________________________________ Where does your child go to school? ____ School District: ____ Grade: ___________________________________
Does your child have an IFSP, IEP or 504 plan? Yes No
Does your child have difficulty with any of the following? (Check all that apply) Memory Tasks Remembering and following directions Comprehension Putting thoughts together Word Retrieval Difficulty learning/using new vocabulary
Does your child have difficulty learning early academic skills such as matching, identifying same/different, and/or knowing names of colors, shapes, numbers and letters? Yes No If yes, please describe:____
Does your child have difficulty learning skills in reading, math, spelling, other? Yes No If yes, please describe:____

Is your child receiving special help with learning skills? Yes No If yes, please explain:____________________
Do you have concerns about your child's learning skills? Yes No If yes, please explain:____________________

Sensory and Motor
Does your child have any difficulty walking, running, sitting, or other large motor skills? If yes, please describe:____________________
Is your child clumsy or does he/she fall easily? Yes No Does your child have low body tone? Yes No
Does your child have difficulty with fine motor skills such as stacking, cutting, and handwriting? Yes No If yes, please describe:____________________
Is your child sensitive to certain textures of food or clothing? Yes No If yes, please explain: ____________________ Does your child dislike having substances on his/her hands (e.g. glue or dirt)? Yes No
Is your child oversensitive to being touched/dislikes being touched? Yes No If yes, please describe:____________________

Check all that apply regarding your child:

- Dislikes washing his/her face or hair
- Puts things in his/her mouth besides food
- Spends too little or too much time brushing his/her teeth
- Does not demonstrate caution
- Dislikes haircuts
- Chews on his/her clothes

Behavior

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

- Difficulty staying on task
- Tantrums
- Sensitive
- Difficulty finishing tasks
- Passive in interactions
- Very active
- Underactive
- Angry/acting out behavior
- Frustrated
- Inattentive
- Refuses to perform tasks
- Shy
- Reduced or lack of interaction with others

Other Information

Who does your child play with? (Check all that apply)

- Both parents
- Grandparents
- Foster parents
- Mother only
- Father only
- Parent + Stepparent
- Other: ____________________________

Are languages other than English spoken in the home? Yes No

If yes, please list: ____

Has your child had a previous speech-language therapist? Yes No

If yes, please list dates, setting(s), and therapist(s): ____

____

If your child had speech-language therapy, what kind of progress did your child make?

____

Were you pleased with your child's progress? Yes No

Please explain:____

Has your child been evaluated by any other professional: (Check all that apply)

Educator/Teacher Occupational Therapist (OT) Neurologist

Geneticist Psychologist/Psychiatrist Physician

Physical Therapist (PT) Developmental Pediatrician (Specialist)

Other:____

Does your child have a diagnosis from any of the above professionals? Yes No

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

____

What other concerns do you have about your child? ____

____

Does your child currently receive services from any of the following professionals (in the school district or in a private setting):

Special Educator/Teacher Occupational Therapist (OT) Neurologist

Psychologist/Psychiatrist	Physical Therapist (PT)	Developmental Pediatrician (Specialist)
Speech Therapist	Dietitian	Other:____________________________

What do you consider to be your child's greatest strengths? ____________________________________

____

What do you hope to gain from this evaluation? ____

____

Was this evaluation recommended by another professional? Yes No

If yes, by who, and what concerns were shared with you?

____

____