Pediatric Speech and Language Questionnaire

Please complete the following form and mail or email to ReImagine Speech Therapy prior your child's Speech Therapy Evaluation.

Demographics
Name of Child ____
Date of Birth ___________________
Chronological age _____________
Gestational age ________________
Current weight ________________
Mother's name ____
Mother's occupation _____________________________________
Father's name ____
Father's occupation _______________________________________
Are both parents in the home with your child? __________

Brother and sisters (include names and ages)
____
____
____
____

Who lives in the home with your child?
____

General Information
What languages does your child speak? What is your child's dominant language?

What languages are spoken in the home? What is the dominant language spoken?

With whom does your child spend most of his/her time?

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Describe your child's speech-language difficulties?

How does your child usually communicate (grunting, gestures, words, sentences)?

When were speech/language difficulties first noticed? By whom?

What do you think may have caused the difficulties?

Have there been any changes since it was first noticed?

Is your child aware of their difficulties? If yes, how does he/she respond to it?

Have any other speech-language specialists seen your child? Who and When? What were their conclusions, suggestions and/or goals?

Have any other specialists (physicians, audiologists, psychologists, etc…) seen your child? If yes, indicate type of specialist, when your child was seen, and their conclusions.

Are there any other speech, language, or hearing deficits in your family? If yes, please describe.

Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents, medications, etc…).

Length of pregnancy _______________ Length of labor _______________________
General condition _________________ Birth weight __________________________
Type of delivery:
____ Head first ____ Feet first ____ Breech ____ Caesarian
Were there any unusual conditions that may have affected the pregnancy or birth?

Medical History
Has your child experienced any of the following? If yes, age and frequency.

________ Asthma	________ Chicken pox	________ Colds
________ Croup	________ Dizziness	________ Draining ear
________ Ear infections	________ Encephalitis	________ German measles
________ Headaches	________ High fever	________ Influenza
________ Mastoiditis	________ Measles	________ Meningitis
________ Mumps	________ Pneumonia	________ Seizures
________ Sinusitis	________ Tinnitus	________ Tonsillitis

Other ____

Has your child had any surgeries? If yes, what type and when?

Describe any major accidents or hospitalizations.

Is your child taking any medications? If yes, please list.

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Have there been any negative reactions to medications? If yes, identify.

Developmental History

Provide the approximate age at which your child began to do the following activities:

________ Crawl ________ Sit ________ Stand
________ Walk ________ Feed self ________ Dress self
________ Use toilet

Use of single words (i.e. mom, dad, no) ______________________________

Combine words (i.e. me go, dad show) ______________________________

Name simple objects (i.e. dog, car, tree) ______________________________

Use simple questions (i.e. where's doggie?) ______________________________

Engage in conversation ______________________________

Does your child have difficulty walking, running, or participating in other activities, which require small or large muscle coordination?

Are there or have there ever been any feeding problems (i.e. problems with sucking, swallowing, drooling, chewing)? If yes, describe.

Describe the child's response to sound (i.e. responds to all sounds, responds to loud sounds only, inconsistently to sounds).

Educational History

School ______________________________ Grade __________

Teacher(s) ______________________________

How is your child doing academically (or preacademically)?

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Does your child receive special services? If yes, describe.

How does your child interact with others (i.e. shy, aggressive, uncooperative)?

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe the most important goals.

Provide any additional information that might be helpful in the evaluation or remediation of your child's deficits.

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