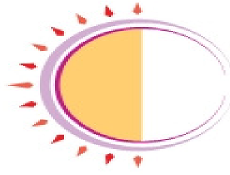

CONFIDENTIAL PARENT QUESTIONNAIRE FOR SPEECH/LANGUAGE & HEARING EVALUATION

(All information provided is strictly confidential and will not be provided to any other agency without your written consent.)

Child's Name: ________________________________ **Evaluation Date:** ___________________________
Child's Age: __________________________________ **Date of Birth:**______________________________
Mother's Name: ____________________________ **Age:** ______ **Occupation:** ________________________
Father's Name: _____________________________ **Age:** ______ **Occupation:** ________________________
Referred to Creative Therapy Works, LLC by: ____

I. GENERAL INFORMATION

1. Describe what concerns you have about your child's development: ____________________________
____
____
____

2. When did you first notice this problem? ____
____

3. List other professionals who have evaluated your child and any diagnosis made (include dates):
_______________________________________ ___________________________________
_______________________________________ ___________________________________
_______________________________________ ___________________________________

4. Has your child received any previous treatment for this specific problem? ____ yes _____no

5. If yes, where/when: ____
____
____

6. Is a second language spoken in the home? ______ If so, what language? __________________________

7. Please list brothers and/or sisters of the child and their ages:
____
____

8. Please list any additional people living in your home, their ages, and relationship to child:
____
____

9. What specific questions do you have relating to this evaluation and your child's speech/ language?
____
____
____

II. DEVELOPMENTAL HISTORY

A. Prenatal:

1. How was the health of the mother during this pregnancy? ____
____

2. Any accidents or illnesses? _____________________ **If so, please explain briefly:** __________________
____

3. Has the mother had any problems with other pregnancies before or after this? _________ If so, please explain: ____

4. Please check any conditions that applied to the mother during this pregnancy:
____Nervous & apprehensive ____RH negative ____Unusually happy ____Moody ____Headaches

____High blood pressure ____Virus infections ____German Measles ____Toxic condition
____ Bed rest or hospitalization ____ Use of Pitocin or Breathine
Other: ____
5. If mother had German Measles (Rubella) or was exposed to it, please give month of gestation in which it occurred(first, second, third, etc.): ____
6. If virus infections, give type and month occurred: ____
7. Did the mother take any medication or drugs during this pregnancy? ______ If so, what? _____________
____

B. Peri-natal:
1. Weight of child at birth: _______ pounds, ______ounces
2. Duration of pregnancy: ______________months
3. Was there false labor? _______________
4. How long was labor? ________________
5. How long before delivery did water break? ___________________________
6. Were instruments used? _________ If so, what? _______________________________
7. What kind of anesthesia was given to the mother? ______________________________
8. Was the delivery: ___Spontaneous ____Induced ____Cesarean Section ___ Breech
9. Was there anything unusual in the baby's condition at birth or soon after, such as:
____ Injury ___ Paralysis ____ Cord wrapped around neck _____Bruises
____ Coloring (blue or yellow) ____ Other (explain): __________________________
10. Was the baby given blood transfusions or exchanges at birth? ______________________
11. Was the baby given oxygen? ___________________________
12. Were there any problems after birth? _____ Such as: ____ Feeding problems _____ Seizures ______
Other Illness: (explain) ____
____

III. FEEDING HISTORY
Circle "yes" or "no" to indicate if your child has/ had any difficulty with the following:

Yes No	Problems with sucking/ nursing	Transition from bottle to baby food	Yes No
Yes No	Choking or gagging	History of aspiration	Yes No
Yes No	Reflux	Difficulty chewing or swallowing	Yes No
Yes No	Does your child feed self with a spoon?	Regurgitation of liquids or solids through nose	Yes No
Yes No	Does your child drool?	Tube feeding (NG, OG, or g-tube)	Yes No
Yes No	Does your child avoid food textures? If yes, please explain: ______________________ ______________________	Is your child a picky eater. If "yes" what food does he/she prefer? ______________________ ______________________	Yes No

IV. PLAY BEHAVIORS
Does your child enjoy/ do the following:

Yes No	Look at books	Putting toys in mouth	Yes No
Yes No	Rough and tumble play	Use objects appropriately	Yes No
Yes No	Role play	Playing with others	Yes No
Yes No	Make- believe play	Playing alone	Yes No
Yes No	Games with rules	Playing with repetitive toys	Yes No
Yes No	Acting out familiar routines		

V. MOTOR DEVELOPMENT

1. At what age did the child do the following?

_____ Head support
_____ Sit alone
_____ Crawl
_____ Walk alone
_____ Drink from a cup
_____ Pull off his socks
_____ Eat with spoon
_____ Ask to go to the toilet

2. Does the child:

____ Prefer the right or left hand?
____ Fall, lose balance easily
____ Grasp objects readily?
____ Have difficulty chewing and/or swallowing
____ Have a peculiar walk?
____ Seem awkward and uncoordinated?

VI. HEALTH HISTORY

1. Check any illnesses the child has had. Specify information, such as age, degree of temperature, medical treatment received:

☐	**Measles**	☐	**Chicken Pox**	☐	**Frequent Colds**
☐	**Meningitis**	☐	**Convulsions/ Seizures**	☐	**Pneumonia**
☐	**Whooping Cough**	☐	**Mumps**	☐	**Bronchitis**
☐	**Poliomyelitis**	☐	**Falls/ blows to the head**	☐	**Asthma**
☐	**Scarlet Fever**	☐	**Tonsillitis**	☐	
☐	**Influenza**	☐	**Frequent Ear Infections**	☐	
☐	**Epilepsy**	☐	**Allergies**	☐	

2. If you child has had more than one ear infection, how old was the child when the ear infections occurred?
____

3. How were the ear infections treated (antibiotics, tube, etc.)? _______________________________

Check any surgery your child has had. Specify date of surgery, where, duration of hospitalization, and attending physician:

	Date / Duration of Hospitalization	Attending Physician
☐ Tonsillectomy		
☐ Adenoidectomy		
☐ Ear Surgery		
☐ Oral Surgery		
☐ Other:_____________		
☐ Other: _____________		
☐ Other: _____________		

3. Is the child presently on medication? _______ If so, specify by name and reason prescribed:
____

4. Are there any members of the family who have hearing or speech difficulties? _____ If so, please specify who and what the difficulty was: ____

5. Does any member of the family have similar problems that the child has? _______________________

6. Is child allergic to food, drink, insect bites, etc: _____ Explain: ____________________________

VII. EMOTIONAL ADJUSTMENT **(please circle yes or no if the statement is something that currently pertains to your child)**

Yes No	Responsive to people	"Bang" his head on crib, chair or floor	Yes No
Yes No	Especially alert to movements	Eat well	Yes No
Yes No	Sensitive to vibratory sensations	Sleep well	Yes No
Yes No	Highly distractible	Cry, sob, shed tears	Yes No
Yes No	Behavior consistent from day to day	Upset when separated from parents	Yes No
Yes No	Laugh, smile, seems happy	Playful with children, adults and pets	Yes No
Yes No	"Stares" at lights, objects, people, and in	Rocks head while sitting/ standing	Yes No

VIII. HEARING

1. Do you suspect any hearing difficulty?____

2. Has your child's hearing been tested? If yes, When? Where? Results?

____

3. Has your child been diagnosed with a hearing impairment? ______ **If yes, by whom and when; please describe hearing loss that has been diagnosed:** ____

____

4. How do you get the child's attention when his back is turned away? ________________________________

5. Does your child: (Please circle "yes" or "no")

Yes No	Respond to any Sound	Seem to hear but not understand	Yes No
Yes No	Ask to have words repeated	Show fear of any sound	Yes No
Yes No	Respond to doorbell, airplane, horns	Trained in sign language	Yes No
Yes No	Respond Consistently	Wear a hearing aid	Yes No
Yes No	Ignores sound willfully	Gesture to communicate	Yes No

IX. SPEECH AND LANGAUGE DEVELOPMENT (please write "yes" or "no")

Please answer yes or no to the following: When did/ Does the child: (please indicate the age where appropriate)

Yes No	Babble Age:___________	Attempt to imitate speech Age:_______	Yes No
Yes No	Use Jargon Age:___________	Demonstrate understanding of speech	Yes No
Yes No	Vocalize for pleasure	Have a "language of his own"	Yes No
Yes No	Communicate by crying, laughing smiling	Seem to have "lost" any amount of language in the last couple of months	Yes No
Yes No	Use gestures meaningfully	Gesture to communicate	Yes No
Yes No	Refuse to use voice	Have difficulty pronouncing words? Please list sounds__________________ ____________________________________	

Yes No	Have awareness of speech difficulties	Have any problems with their voice	Yes No

Check the way your child most frequently communicates:

- ☐ Words, phrases, complete sentences
- ☐ Looking at objects
- ☐ Pointing to objects
- ☐ Physical Manipulation
- ☐ Sign Language
- ☐ Other:____

IX. AUDITORY PROCESSING

1. Can your child understand directions/and or conversation: ____ yes ____ no
If "no", what behaviors have you observed? ____
____

2. Has your child been diagnosed with an auditory processing disorder? ____ yes ____ no

XI. EDUCATIONAL HISTORY

1. Name of school presently attending: ____
2. Grade or level: ____
3. Describe general progress and behavior in school: ________________________________
____
4. Is the child in special class or receiving tutoring for any reason? If so, specify where and for what reason:
____
5. Does your child display preference for any learning style over another? ____ visual ____auditory ______tactile

XII. ADDITIONAL PARENT COMMENTS

Please provide your personal observations relative to the child's speech/language and/or hearing and behavior:
____
____
____
____

Completed by: ______________________________ Relationship to client: ____________________

Signature: ____________________________________Date: ________________________________