PATHWAYS
SPEECH THERAPY INC.

Name: _____ **DOB:** _____

PARENT QUESTIONNAIRE SPEECH AND LANGUAGE THERAPY

The information you provide here will help us with your child's speech-language evaluation.

Medical or Developmental Diagnoses: _____
School Diagnoses: _____ Language(s) Spoken at Home:_____
Parent/Caregiver's Name: _____ Relationship to Patient: _____
Parent/Caregiver's Name: _____ Relationship to Patient: _____
Brothers/Sisters: 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? _____

REASON FOR REFERRAL

Who referred you to Pathways?_____
What are your main concerns about your child's speech and language skills?
_____
When did you first become concerned with your child's speech and language skills?
_____
What would you like your child to be doing 6 months from now?
_____

MEDICAL HISTORY

Were there any problems during your pregnancy? □ Yes □ No
Were there any problems during your child's birth? □ Yes □ No
What was your child's Apgar Score? _____
Has your child had any significant illnesses, injuries, and/or hospitalizations? □ Yes □ No
If yes to any of the above, please describe: _____
List any medications currently being taken: _____
Does your child have any allergies (medicine, food, environment)? □ Yes □ No
If yes, please list: _____
Has your child been evaluated by an ear, nose and throat (ENT) doctor? □ Yes □ No
If yes, why: _____
Does your child have a history of frequent ear infections? □ Yes □ No
If yes, please describe: _____
Does your child have ear (PE) tubes? □ Yes □ No

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Has your child's hearing been tested? □ Yes □ No
If yes, when: _____ where (school, clinic, etc): _____
Results: _____

Has your child been seen by a psychologist/psychiatrist? □ Yes □ No
If yes, when: _____ where (school, clinic, etc): _____
Results: _____
Does your child have behaviors that: Impact learning/school? □ Yes □ No
Interfere with social interactions? □ Yes □ No
Are they aggressive towards self? □ Yes □ No
Aggressive towards other people? □ Yes □ No
Aggressive towards objects/property? □ Yes □ No
If yes to any of the above, please explain: _____
Does your child have a behavior plan? □ Yes □ No
If yes, please explain: _____

MOTOR DEVELOPMENT

At what age in months or years did your child:
Hold their head up: _____ Stand: _____
Roll over: _____ Walk: _____
Crawl: _____ Babble: _____

FEEDING DEVELOPMENT

Is your child's weight gain a concern? □ Yes □ No
If yes, please explain: _____
Does or did your child have difficulty starting to eat solid foods? □ Yes □ No
Does or did your child have difficulty swallowing? □ Yes □ No
Does your child allow his/her teeth to be brushed? □ Yes □ No
Will your child allow you to touch his/her mouth on the inside? □ Yes □ No

SPEECH AND LANGUAGE DEVELOPMENT

How often does your child use the following ways to communicate?

1 word:	Never	Rarely	Occasionally	Frequently
2 word phrases:	Never	Rarely	Occasionally	Frequently
3 or more word sentences:	Never	Rarely	Occasionally	Frequently
Gestures:	Never	Rarely	Occasionally	Frequently
Signs:	Never	Rarely	Occasionally	Frequently
Communication Device:	Never	Rarely	Occasionally	Frequently

Does your child have a communication device? □ Yes □ No
If yes, what type of device?_____
Does your child respond to his/her name? □ Yes □ No
Does your child try to get you to notice interesting objects? □ Yes □ No
When you point to a toy across the room, does your child look at it? □ Yes □ No
Does your child engage in pretend play with toys? □ Yes □ No

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Does your child play well with other children? □ Yes □ No
If yes, what ages? _____
Do you have concerns about your child stuttering? □ Yes □ No
If yes, when did the stuttering begin? _____
If yes, has anything helped decrease your child's stuttering? _____
_____
If yes, Does your child seem to be aware of the stuttering? □ Yes □ No
Do you have concerns about your child's voice (i.e. soft, hoarse, loud)? □ Yes □ No
If yes, please explain: _____

THERAPY
Has your child's speech-language development been evaluated before: □ Yes □ No
If yes, when: _____ where (school, clinic, etc): _____
Results: _____
Is your child currently receiving Speech Therapy? □ Yes □ No
If yes, how often: _____ where: _____
Occupational Therapy? □ Yes □ No If yes, how often: _____ where: _____
Physical Therapy? □ Yes □ No If yes, how often: _____ where: _____

EDUCATION
Does your child attend daycare? □ 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

FAMILY HISTORY
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/Learning Disability: □ Yes □ No If yes, who?_____
ADHD: □ Yes □ No If yes, who? _____

Additional comments or concerns you would like us to be aware of:
_____
_____
What does your child enjoy doing or playing with? _____
What motivates your child?_____