

Speech Therapy Consultation

Child's Name:	DOB:
Parent's Name:	Phone #:
Address:	
E-Mail:	
Has the child had a hearing te	est?()Yes()No
1. Why are you seeking a speech therapy consultation	on?
2. What do you hope to gain out of today's visit?	
3. Is the concern about sounds s/he is making/ not r	making?
4. Is the concern about the words s/he is making/ no following directions?	ot making, answering questions, and/or

5.	Is the concern about using language with other people (ie. responding to questions, playing, turn taking, engaging with other)?
6.	Does he/she speak smoothly? Is stuttering a concern?
7.	Is there a time of day that is difficult? Or a particular task?
8.	If one thing could change about your child's communication, what would be most helpful?
9.	Has s/he ever had a speech evaluation or services? (Ex. EarlyOn, PEPT, KRESA). If so, can you bring that eval or any forms necessary. If not, what have you tried at home?