Aspire speech therapy

## Confidential Parent Questionnaire

### Background Information

Today's Date: _____

Child's Name: _____ Date of Birth: _____ Age: _____ Sex: M F
Name of person completing this form: _____ Relation: _____
Father's Name: _____ Mother's Name: _____
Father's Employer: _____ Mother's Employer: _____
Business Phone: (___) _____ Business Phone: (___) _____
Child lives with: _____ Primary Caregiver: _____
Home Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: (___) _____ Cell Phone: (___) _____ Referred By: _____
Email Address (please print legibly): _____
Reason for referral: _____

### Pregnancy, Birth, and Medical History

Child's Primary Care Physician: _____ Phone: (___) _____
Does your child see other physicians/professionals (e.g., neurologist, behaviorist)? YES NO
If yes, please list: _____
Please list any problems during pregnancy or delivery: _____

Has your child ever had:

- Frequent headaches Y N
- High fevers Y N
- Head injury/concussion Y N
- Chronic colds Y N
- Chronic ear infections Y N
- PE tubes in ears Y N
  Date/s placed:
- Epilepsy/Seizures Y N Date of last:
- Asthma Y N
- ADD/ADHD Y N
- Tonsillectomy Y N Date:
- Adenoidectomy Y N Date:
- Emotional/psychological problems Y N

Please describe any serious illnesses, hospitalizations, and/or surgeries: _____

Please list any current medications and reasons for the medication(s): _____

Please list any allergies or food restrictions that your child has: _____

Is your child on a special diet? Y N If yes, explain: _____
Has your child's vision been tested? Y N
If yes, when and by whom? _____ Results: _____
At what age did your child:
Crawl: _____ Walk: _____ Self-feed: _____ Toilet Independently: _____
Which hand does your child prefer using? _____

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## Hearing History

Has your child's hearing been tested? Y N
If yes, when and by whom? _____ Results: _____
Does your child have a history of earaches or ear infections? Y N
If yes, please explain: _____
Did your child ever have PE tubes? Y N If yes, when? _____
Have you ever suspected that your child has or had difficulty hearing? Y N
If yes, please explain: _____

## Family History

Has any member of the child's family had: Relationship to child:

- Speech or language problems Y N _____
- Hearing problems as a child Y N _____
- Hearing problems as an adult Y N _____
- Learning disability Y N _____
- Reading problems Y N _____
- ADD/ADHD Y N _____
- Autism/PDD Y N _____
- Cleft lip or palate Y N _____
- Fluency disorder/stuttering Y N _____
- Other (please specify) Y N _____

| Brothers/Sisters (names): | Age: | Sex: | Please list any medical/developmental problems: |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

### Speech & Language History/Concerns (for Speech Therapy evaluation only)

What are your primary concerns regarding your child's communication/speech and language?

_____

_____

When did you first become concerned? _____

What languages are spoken in the home? _____
What is the primary language spoken in the home? _____
What is the primary language used by your child? at home: _____ at school: _____

At what age did your child:
Say his/her first word: _____ Combine 2-3 words: _____ Produce a sentence: _____
How does your child primarily communicate at this time (e.g., pointing, taking you to desired item, tantrum, single words, sentences, picture system, etc.)?: _____

_____

_____

Did your child's speech or language development ever seem to stop or did your child stop talking altogether? Y N If yes, when? _____

What percentage of the time do you understand what your child says?
_____ 0-25% _____ 25-50% _____ 50-75% _____ 75-100%
What percentage of the time do relatives or close friends understand what your child says?
_____ 0-25% _____ 25-50% _____ 50-75% _____ 75-100%
What percentage of the time do less familiar people/strangers understand what your child says?
_____ 0-25% _____ 25-50% _____ 50-75% _____ 75-100%

Please list any sounds your child has difficulty producing: _____
Does your child get stuck on sounds, repeat sounds, hesitate, or stutter? _____

Does your child show frustration or embarrassment due to speech/language difficulties? Y N
If yes, please explain: _____

How many words does your child: produce at this time? _____ understand at this time?_____
At what rate does your child speak? _____ Slow _____ Normal _____ Fast

Can your child identify: simple body parts Y N articles of clothing Y N
Can your child follow: simple directions Y N more complex directions Y N
Please provide examples: _____
_____
_____
What percentage of the time does your child understand you? _____
Please list any concerns that you have regarding your child's understanding: _____
_____

Please describe how your child interacts/plays with other children: _____
_____

Please describe any behavior problems your child may exhibit at home or when out in public:
_____

Does your child have any feeding or swallowing difficulties? Y N Explain: _____
_____
Is your child a picky eater? Y N
Please explain if your child has any food preferences or avoids certain foods: _____
_____
Has your child ever drooled profusely? _____ Did your child suck his/her thumb? _____
Was a pacifier used? Y N At what age was it weaned? _____
Does your child breathe with his/her mouth open? _____
Does your child's tongue frequently protrude (stick out) past the lips? _____

Has your child ever received a speech and language evaluation and/or therapy? Y N
If yes, please explain: _____

## Preschool/School History

Does/did your child attend preschool? Y N If yes, where? _____
Does your child participate in play groups or other community activities (e.g., gym class)? Y N
If yes, please explain: _____

_____

Does your child attend school? Y N If yes, where? _____
What grade is your child in: _____ Teacher's Name(s): _____
What is your child's favorite subject? _____ Least favorite: _____
What is your child's best subject? _____ Most difficult: _____
Does your child receive special education services? Y N If yes, please explain: _____

_____

Have teachers expressed concerns about the child's performance and/or behaviors in the classroom? Y N If yes, please explain: _____
Please list any concerns you have regarding your child's learning and/or school performance:

_____

*If your child has an IEP, please bring it to the evaluation.*

## Other

What hobbies, activities, and interests does your child have? _____

_____

Please list any activities, objects, or foods that are reinforcing for your child: _____

_____

Is there anything that your child is unusually afraid of? _____

If any, what concerns other than speech and language do you have regarding your child?

_____

_____

Please list any additional comments or questions: _____

_____

_____

Thank you for taking the time to fill out this questionnaire!
If you have any questions while completing this form, please let us know.

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