Speech Inspiration, PLLC

Original Date:	2013
Dates Revised:	2017

PEDIATRIC QUESTIONNAIRE

All questions contained in this questionnaire are optional and your answers will be kept strictly confidential. If you do not recall information for a particular item, leave it blank. If an item does not apply to your child, mark the item, NA (not applicable).

CHILD

Name *(First, Middle, Last)*	☐ **M** ☐ **F**	**DOB:**	**AGE: __Yr___Mo___**
Address *(Street, City, Zip):*			
Parent's Names:			
Home Phone:	**Referred by:**	**Referral Phone:**	
Please describe your concerns regarding your child:			
Where did you hear about Speech Inspiration?			
When did you first become concerned about your child's speech and /or language?			
Are you aware of any contributing factors (e.g. traumatic birth, family history, accident/injury/illness)?			
Language(s) Spoken at Home: **Dominant Language:**	**Adopted?** ☐ **Yes** ☐ **No** **If yes, provide adoption date:**		

PRIMARY CARE PROVIDER

Name/Specialty:	**Address:**	**Phone (Office):**
Fax:	**Email:**	

EMERGENCY CONTACT

Emergency Contact *(Name/Relationship):*	**Phone(s):**
Emergency Address *(Street, City, Zip):***:**	**Email:**

FAMILY

List family members with a speech, language, hearing or learning problem ***(explain problem):***	
Marital Status of Parents:	☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Child's Name_____

Mother		
Name:		**DOB:**
Phone (Office):	**Phone (Mobile):**	**Phone (Work):**
Highest Education Level:		
Occupation:	**Email:**	
Work Address ***(company name, street, city, zip):***		

Father		
Name:		**DOB:**
Phone (Office):	**Mobile:**	**Work:**
Highest Education Level:		
Occupation:	**Email:**	
Work Address ***(company name, street, city, zip):***		

Siblings and Other
Names and ages of brothers and sisters (indicate step relationships):
Other persons living in the home and relationship to the child:

PREGNANCY AND BIRTH HISTORY

Describe any complications during pregnancy:		
Length of pregnancy:	**Duration of pregnancy:**	
Anesthesia used:	**Duration of labor:**	
Apgar scores:	**Weight at birth:**	**Length at birth:**
Did he/she breathe promptly at birth? ☐ Yes ☐ No **If no, please explain:**	**Was oxygen required at birth? ☐ Yes ☐ No** **If yes, please explain:**	
Was the infant blue? ☐ Yes ☐ No	**Scars or bruises during birth?** **☐ Yes ☐ No If yes, please explain:**	**Was the infant jaundiced? ☐ Yes ☐ No**

NEONATAL AND INFANT HISTORY

Child's Name_____

Did the infant have sucking or swallowing difficulty? ☐ Y ☐ N **If yes, please explain:**	**Seizures? ☐ Y ☐ N If yes, please explain:**
Feeding problems since birth? ☐ Yes ☐ No If yes, please explain:	
Hospitalizations within the first two weeks of birth? ☐ Yes ☐ No If yes, please explain:	

HEALTH AND MEDICAL HISTORY

We would appreciate having any test results or information from your providers.

Current medical diagnoses *(if any):*

Has your child been seen by any of the following specialist if so, provide detail *(name, address, phone, reason and reports)***?**

Otolaryngologist:

Pediatric Neurologist:

Neurosurgeon:

Psychiatrist:

Neuropsychologist:

Psychologist:

Pediatric Gastroenterologist:

Physiatrist:

Plastic Surgeon:

Oral Surgeon:

Other:

Has your child ever had a *(check all that apply and provide reason):* **☐ CT Scan ☐ MRI ☐ EEG ?** **Reason:**	**Date of last hearing test?** **Results of hearing test: ☐ Pass ☐ Fail** *Please provide a copy of the screening or diagnostic evaluation* **Does your child wear a hearing aid? ☐ Yes ☐ No** **(***If so how long does he/she wear the hearing aid?)* **Are your child's ear infections controlled by medication? ☐ NA ☐ Yes ☐ No**
Date of last vision screening test?	**Results of screening/test: ☐ Pass ☐ Fail (***If failed, what is your child's vision?)*

Child's Name_____

	Is your child currently wearing glasses? ☐ Yes ☐ No

Does your child have any food allergies? ☐ Yes ☐ No If yes, please list all foods that your child is allergic to and their type of reactions to it.

Does your child have or had any of the following conditions *(check all that apply)***?**

Attention Deficit Disorder/ Attention Deficit Hyperactivity Disorder "ADD/ADHD"		Bronchitis/Pneumonia	
Asthma		Headaches	
High fevers		Seizures	
Colic		Chronic colds *(state # of colds per year)*	
Congenital heart disease		Head Injury	
Autism		Chronic illness (explain)	
Mental Retardation		Cerebral Palsy	
Speech disorder/delay		Down Syndrome	
Swallowing problems		Mental illness	
Cancer		Myringotomy/tubes inserted	
Ear infections *(state the # of infections per year)*		Allergies	
Sensorineural hearing loss		Skin rash	
Tonsillitis/tonsillectomy		Cleft lip and/or palate	
Chronic stomach aches		AIDS/HIV	
Learning Disability		Other illnesses or surgeries *(hernia, mumps, croup):*	

Has your child been hospitalized? ☐ Yes ☐ No If yes, please explain why:

Has your child had surgery? ☐ Yes ☐ No If yes, please explain why:

Were there noticeable changes in your child's level of function (speech, cognition, motor skills) immediately following any illness or surgery?
☐ Yes ☐ No If yes, please describe:

Are there any medical precautions of which the Speech Pathologist should be aware of when with your child?

Do you have any health concerns about your child?

CURRENT MEDICATIONS

Child's Name_____

Does your child have any medication allergies? ☐ Yes ☐ No If yes, please explain:

Your child's medication list	Strength	Frequency Taken

DEVELOPMENTAL HISTORY

What developmental concerns do you have about your child?

Does your child seem to be: ☐ Right Handed ☐ Left Handed

Developmental Milestones: *Record the age for each milestone below.*

Motor *Approximate age when child:*	Rolled over	Sat alone without support	Slept through the night
	Began to army crawl	Began one leg crawl	Cruised along furniture
	Walked without assistance	Toilet trained	Can dress self independently
	Skipped	Manipulated fasteners	Undress independently
Speech & Language *Approximate age when child:*	Babbled	Answered simple questions	Could name primary colors
	First word	Asked "why" questions	Could write his/her name
	Put 2 words together	Used grammar like rest of family	Could read a simple story
Swallowing/Feeding/Eating *Approximate age when child:*	Could eat independently with finger food	Could drink from a cup	Could drink with a straw
	Transitioned to baby food	Used a spoon independently	Used a fork independently
	Could independently cut with own knife	Could eat independently	Could pour own drink
	Could get own snacks	Could prepare own meal	

What are your child's favorite foods?

What are your child's least favorite foods?

Child's Name_____

SCHOOL PERFORMANCE

My child attends (check all that apply): ☐ Day Care ☐ Elementary School ☐ High School

Grade:_____

School Name and District:	**Teacher's Name:**
Address:	**Email:**
Phone :	**Fax:**
Day Care Name:	**Phone:**
Address:	

Describe your child's general progress and performance at school?

Has your child ever repeated a grade? ☐ Yes ☐ No If yes, please explain

What special services does your child receive at school? ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Counseling ☐ Resource ☐ Tutoring *(please provide name, any assessment reports or ARD reports and contact information for each service provided)*

What special services does your child receive privately? ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Counseling ☐ Tutoring *(please provide name, any reports and contact information for each service provided)*

How well does your child get along with other children at his/her school?

Are there any concerns about your child's school experience that you would like your speech-language pathologist to know about?

SOCIAL DEVELOPMENT

Does your child get along with others in his/her neighborhood? Please explain if answered, no.	☐	**Yes**	☐	**No**
Does your child play with other children of the same age? Please explain if answered, no.	☐	**Yes**	☐	**No**

Child's Name_____

Does your child participate in any organized activities afterschool or have any hobbies? Please explain if answered, yes.	☐	**Yes**	☐	**No**
Do you have any concerns about your child's behavior? Please explain if answered, yes.	☐	**Yes**	☐	**No**

SPEECH, LANGUAGE AND HEARING QUESTIONNAIRE

Check all that conditions that apply to your child

☐ Not understood by parents	☐ Mute	☐ Easily distracted
☐ Not understood by strangers	☐ Avoids talking	☐ Interrupts constantly
☐ Continues to mispronounce speech sounds after age 7	☐ Does not follow directions	☐ Misses intent of the message
☐ Mispronounces sounds under age of 7	☐ Difficulty locating direction of sound	☐ Doesn't speak up
☐ Nasal speech	☐ Has difficulty remembering the main point of the story	☐ Stammers or stutters while talking
☐ Excessively loud voice	☐ Points instead of talking	☐ Hoarse voice
☐ Excessive talking	☐ Writing is full of grammatical errors	☐ Plays TV, stereo, radio excessively loud
☐ Has difficulty with time sequences (e.g. before, after, first, second, today, yesterday etc.)	☐ Writing is unorganized	☐ Thought expression is disorganized
☐ Significant spelling errors	☐ Has difficulty in taking turns during a conversation	☐ Has difficulty with inferences

SWALLOWING/FEEDING/EATING QUESTIONNAIRE

Check all that conditions that apply to your child

☐ Difficulty nursing or taking a bottle	☐ Intolerance of certain food textures	☐ Clenches teeth
☐ Difficulty transitioning to baby food	☐ Tongue movement is poorly coordinated	☐ Grinds teeth
☐ Difficulty drinking from a cup	☐ Unable to lift tongue tip	☐ Underweight for age
☐ Difficulty with chewing or clearing food from mouth	☐ Chokes while eating	☐ Picky eater
☐ Difficulty with swallowing	☐ Drools	☐ Chokes easily (liquids or solids)
☐ Reflux	☐ Drooling increases with concentration on difficult tasks	☐ Shallow breathing
☐ Difficulty eating solid foods	☐ Laborious swallow	☐ Mouth breather
☐ Lengthy eating time	☐ Unable to manage certain types of food	☐ Poor breath support for speech
☐ Difficulty drinking from a straw	☐ Evidences shallow breathing	☐ Gags easily
☐ Still relies on pacifier or sucks thumb	☐ Chews on non-food items	☐ Poor lip closure on eating, drinking, utensils

COORDINATION & MOTOR QUESTIONNAIRE

Check all that conditions that apply to your child

☐ Difficulty with action sequences (e.g. ball catching, batting a ball)	☐ Difficulty with timing and rhythm of movement	☐ Prefers talking to doing
☐ Difficulty with toy assembly	☐ Problems with construction and/or manipulation of materials	☐ Uses disorganized approach to tasks

VISUAL SKILLS QUESTIONNAIRE

Check all that conditions that apply to your child

☐ Inconsistent eye contact during a conversation	☐ Reverses letters, numbers, words	☐ Prefers talking to doing
☐ Difficulty with assembling puzzles	☐ Skips words or lines or loses place while reading	☐ Visually distracted by busy environment

RETURN COMPLETED FORM TO: jjohnson@speechinspiration.com or Fax: 480.287.8474
Speech Inspiration, PLLC – 7122 Midnight Pass – Missouri City – Texas 77459

Child's Name_____

MOVEMENT/BALANCE QUESTIONNAIRE *Check all that conditions that apply to your child*		
☐ Has difficulty sitting still or fidgets/wiggles	☐ Fearful or hesitant when climbing or descending stairs	☐ Trips easily; clumsy, appears uncoordinated
☐ Poor balance on uneven surfaces	☐ Fearful of heights	☐ Demonstrates poor safety awareness
MUSCLE-JOINT SENSE/BODY AWARENESS QUESTIONNAIRE *Check all that conditions that apply to your child*		
☐ Resists new physical challenges, saying "I can't without attempting	☐ Weak pencil grasp, hand tires easily	☐ Uses too much pencil pressure or too little pencil pressure
☐ Appears lethargic or prefers sedentary play	☐ Difficulty controlling movements, uses too little or too much force	☐ Leans on objects/people for stability, props head up on hand
SOCIAL/EMOTIONAL QUESTIONNAIRE *Check all that conditions that apply to your child*		
☐ Impulsive, difficulty staying on task	☐ Appears dependent on others	☐ Excessive tantrums
☐ Struggles to adjust to changes in routine	☐ Seems immature for age	☐ Easily frustrated, irritable, stubborn

FINAL COMMENTS *Please add any information that you feel will help us understand your child below:*

_____
Parent/ Guardian Printed Name

_____ _____
Parent/ Guardian Signature Date