CHILDRENS PROGRAM SPEECH DEVELOPMENT QUESTIONNAIRE

Please complete this form only if you have a scheduled evaluation appointment with
our Speech-Language Pathologist.

Child/Patient's Name: _____ _____ B.D. _____
Last, First (Full Legal Name) (Name to Address Child)

Age _____ Grade_____ Gender Identity: M F Nonbinary Other _____ Birth Sex: M F

School _____

Person completing form: Biological Parent Adoptive Parent Step Parent Grandparent Other
Other, describe_____

Child lives with _____

Referred by (check all that apply): ☐ self ☐ physician ☐ client/friend ☐ school ☐ clinician ☐ insurance

Have you had services at the Children's Program before? No Yes

(if yes, describe) _____

Specific areas of concern (check all that apply)

☐ Late talker
☐ Speech sound development (e.g. has trouble pronouncing or sequencing certain sounds or words, mumbles or is hard to understand)

How intelligible is your child to the following listeners?

Parents/very familiar listeners: Choose percent. 100%

Somewhat familiar listeners (e.g. peers/teacher/extended family): Choose percent. 100%

Strangers: Choose percent. 100%

☐ Expressive Language (e.g. difficulty organizing/expressing thoughts and ideas, vocabulary and word finding, use of accurate grammar)
☐ Receptive Language (e.g. difficulty following directions, understanding instructions)
☐ Literacy – reading/writing/spelling
- ☐ Decoding (sounding out words when reading)
- ☐ Fluency (speed and accuracy when reading)
- ☐ Spelling
- ☐ Written Expression
- ☐ Reading Comprehension

☐ Voice quality (e.g. hoarse, raspy, high-pitched)
☐ Stuttering
☐ Social Communication/Pragmatics (reading social cues, conversational skills, nonverbal communication)
☐ Play skills

Today's Date _____

☐ Feeding and Swallowing (e.g. limited food repertoire, tongue-thrust swallow, unable to manage age appropriate diet)
☐ Other:

When did you first start having the above concerns?
Has your child had previous speech language pathology evaluations or therapy? If yes, please describe:

Developmental Information:

As an infant, did your child babble and play with sounds? ☐ Yes ☐ No ☐ Less than expected ☐ Later than expected At about what age did your child meet the following milestones? Spoke first words: Used 2-word phrases: Sat alone: Stood alone: Crawled: Walked alone: Dressed self: Bladder trained: Bowel trained: Was child's rate of growth seemingly normal? Was development interrupted by anything? Does your child have current difficulty with gross or fine motor tasks?

Medical History

Current diagnoses:

Any other suspected diagnoses:

Current Medications:

Prescribing Physician:

Please note any prenatal or birth complications:

Check all that apply: ☐ Adenoidectomy ☐ Tonsillectomy ☐ Allergies. If yes, Describe: Click or tap here to enter text. ☐ Breathing difficulties/Asthma ☐ Frequent upper respiratory infections ☐ GERD/Acid Reflux ☐ Frequent headaches ☐ Frequent colds ☐ Sinus problems	☐ Frequent ear infections ☐ Tubes in ears ☐ Head injury ☐ Seizures ☐ Loss of consciousness ☐ Sleeping difficulties/disorder. If yes, please describe: Click or tap here to enter text. ☐ Snores ☐ Tosses and turns ☐ Doesn't wake rested ☐ Other significant medical information: Click or tap here to enter text.

Child's Name _____ Date:

☐ Vision problems/Describe:

Dental and Oral History

History or current symptoms. Check all that apply: ☐ Cavities ☐ Thumb or finger sucking ☐ Pacifier use ☐ Nail biting ☐ Excessive lip licking or lip biting ☐ Other Chewing or sucking habits ☐ Chin leaning ☐ Excessive saliva/drooling - in the corners of the mouth, during speech, while eating, or during sleep ☐ Mouth breathing ☐ Teeth Grinding or clenching ☐ Jaw pain ☐ Temporomandibular Joint Disorder (TMJD) ☐ Suspected or diagnosed tongue tie	☐ Frenectomy. If yes, at what age? Who performed? ☐ Orthodontics or orthodontics planned If yes, describe: How often does your child: Brush teeth? Floss? ☐ Other significant dental or oral health history:

Feeding History:

Was your child breast fed, bottle fed, or both? For how long?

How did early feeding go?

Check all that apply: ☐ Difficulty with breast feeding (e.g. painful or shallow latch, poor supply, difficulty getting adequate transfer) ☐ Difficulty with bottle feeding (e.g. needed special nipple or special formula) ☐ Slow eater ☐ Fast Eater ☐ Messy eater	☐ Loses food or liquid from the mouth ☐ Eats with mouth open ☐ Uses a sippy cup ☐ Drinks more than one glass of liquid during meals/needs liquid to wash food down ☐ Frequently belches ☐ On a special diet. If yes, please describe: Click or tap here to enter text. ☐ Refuses certain foods/picky eating habits

Child's Name: _____ Date:

☐ Difficulty drinking from a cup ☐ Difficulty chewing ☐ Difficulty swallowing ☐ Digestive problems ☐ Constipation ☐ Coughs/chokes when eating ☐ Gags when eating	☐ Refuses many foods/very picky/restricted eating habits If picky or restricted, what does your child avoid? (e.g. textures, flavors, nutritional categories) Click or tap here to enter text. ☐ Other feeding concerns:

Is there anything else you'd like the speech language pathologist to know about your child?

Child's Name _____ Date: