Today's Date: / /

Who's completing this questionnaire?

Relationship to child:

Child's name: Date of Birth: / /

Please list other programs or therapies in which your child has participated including screening or evaluation:

How did you hear about us?

Tell me about your child's strengths:

Tell me about your concerns:

What have you tried?

Have you observed unusual play, sounds or speech behaviors? If yes, Explain:

How do you describe your child, i.e. personality, temperament?

Are they talkative or quite?

Describe your relationship with your child?

List siblings, parents and any others living in the home, include ages:

Child lives in more than one home?

List people in second home:

Where is your child during the day?

School: ☐ Yes ☐ No What is your School district?

School Speech Therapy? ☐ Yes ☐ No Minutes per week

Which language(s) does your child hear on a regular basis?

Hours of "screen time": TV: a.m. , p.m. , Video Games: a.m. , p.m. ,

Computer: a.m. , p.m. , Phone/Tablet/Hand-held Games:a.m. , p.m.

Hours of large movement play daily: Hours of quite time: Nap? From to

Amount of time spent with other children: Child's favorite family activities:

Birth History

Born at weeks gestation

Birth Weight:

☐ Yes ☐ No Was child premature?

☐ Yes ☐ No Cesarean?

☐ Yes ☐ No Pregnancy complications?

☐ Yes ☐ No Concerns at birth?

☐ Yes ☐ No Did baby stay in the ICU?

☐ Yes ☐ No Surgery?

☐ Yes ☐ No Tongue Tie?

☐ Yes ☐ No Physical or Occupational Therapy?

☐ Yes ☐ No Saw Neurologist or other specialists?

APGAR scores:

If yes, explain:

Length of ICE/Hospital stay:

☐ Yes ☐ No Breast fed?

☐ Yes ☐ No Difficulty sucking or feeding?

☐ Yes ☐ No Colic?

☐ Yes ☐ No Vomiting?

☐ Yes ☐ No GERD (Reflux)?

☐ Yes ☐ No Low muscle tone?

Developmental History

Did your child:

☐ Yes ☐ No Coo and babble?

☐ Yes ☐ No Babble with various sounds?

☐ Yes ☐ No Use 3 or fewer consonants by 16 months?

☐ Yes ☐ No Have words appear and disappeared?

☐ Yes ☐ No Difficulty imitating speech?

At about what AGE did your Child:

Speak first word: Use two and three words together:

Use sentences: Use toilet: Sit up alone:

Crawl: Walk alone:

Current Physical Growth:

Percentile for height Percentile for wight:

Medical History

Please list all vitamins or medications your child regularly takes:

Other than at birth, has your child ever stayed in a hospital over night? Treated at an emergency room?

Concerns with child's health? If so, explain:

Please describe your child's overall health in the past year:

Please describe any feeding problems your child has experienced:

Difficulty moving to solid food? ☐ Yes ☐ No Very selective eater? ☐ Yes ☐ No Choking? ☐ Yes ☐ No

The following questions pertain to your child at anytime since birth:

☐ Yes ☐ No Has your child seen a neurologist?
Dr. When:

☐ Yes ☐ No Seizures?

☐ Yes ☐ No Trouble seeing/Sits close to TV?

☐ Yes ☐ No Runs into things?

☐ Yes ☐ No Balance problems?

☐ Yes ☐ No Trips easily?

☐ Yes ☐ No Frequent upper respiratory infections (colds, nasal congestion)?

☐ Yes ☐ No Frequent sore throats or strep throat?

☐ Yes ☐ No Has child had his/her tonsils or adenoids removed?

☐ Yes ☐ No Large tonsils?

☐ Yes ☐ No Snoring?

☐ Yes ☐ No Mouth breathing?

☐ Yes ☐ No Asthma?
Explain

☐ Yes ☐ No Allergies?
Explain

☐ Yes ☐ No Cry easily?

☐ Yes ☐ No Often has/had temper tantrums?

☐ Yes ☐ No Easily angered?

☐ Yes ☐ No Unusual behaviors? Explain

☐ Yes ☐ No Oral habits (thumb, pacifier, nail biting)?

☐ Yes ☐ No Concern with tongue or mouth function?

☐ Yes ☐ No Passed newborn hearing screening?

☐ Yes ☐ No Had trouble hearing?

☐ Yes ☐ No Are you concerned about hearing now?

☐ Yes ☐ No Had a hearing test?
Where: When:

☐ Yes ☐ No Had ear infection?
How many: Age starting:
Last infection:

☐ Yes ☐ No Has child had tubes put in ears?
When: By Dr.

☐ Yes ☐ No Are tubes still in place?

☐ Yes ☐ No Has child every seen an ENT doctor?
Explain:

Family History

Have any family members (including siblings, cousins, aunts, uncles, etc.) had any of the following? If you answer yes, please indicate the family members relationship to the child.

☐ Yes ☐ No Speech problems or delays?
If yes, relationship to child

☐ Yes ☐ No Language problems or delays?
If yes, relationship to child

☐ Yes ☐ No Stuttering?
If yes, relationship to child

☐ Yes ☐ No Received special education services at school?
If yes, relationship to child

☐ Yes ☐ No Developmental problems (e.g. metal challenges, autism, schizophrenia, cerebral palsy)?
If yes, relationship to child

☐ Yes ☐ No Learning problems (e.g. reading challenges)?
If yes, relationship to child

☐ Yes ☐ No Chronic illness?
If yes, relationship to child

☐ Yes ☐ No Cleft lip/palate?
If yes, relationship to child

☐ Yes ☐ No Hearing loss or deafness in children?
If yes, relationship to child