Patient Name:

DOB:

MRN:

PARENT QUESTIONNAIRE

Parents – Please fill this form out prior to your child's first evaluation.

DEMOGRAPHIC & FAMILY INFORMATION

Child's Name: ______________________________ Nickname: ________________________

Date of Birth:_________________ Age:___________ Male_____ Female_____

Parent's Name: Mother____

Father____

Address:____

Telephone #:_____________________________ Cell #:___________________________

Pediatrician:_____________________________ Insurance:________________________

Siblings:	Date of Birth:
____	_____________________
____	_____________________
____	_____________________
____	_____________________
____	_____________________

Do any family members have speech, language, learning, or hearing problems?
Yes_____ No_____

If yes, please describe:____

____

PARENT QUESTIONNAIRE

Patient Name:

DOB:

MRN:

SOCIAL/EDUCATIONAL

Child's School______________________________________ Grade/Level:_______

If not school age, other group experience?_______________________________________

How does your child play?

- _____ prefers to play alone
- _____ prefers to play with 1 or 2 others
- _____ plays mostly with siblings
- _____ has a lot of friends

Is your child able to pay attention as well as most other children his/her age?

Yes_____ No_____

MOTOR DEVELOPMENT

List approximate age at which your child demonstrated the following skills:

Crawled______________ Sat up______________

Started to walk______________ Walking unassisted:______________

Any concerns regarding gross motor skills (i.e., walking up/down stairs, running smoothly)?
Yes_____ No____

If yes, please explain____

Any concerns regarding fine motor skills (i.e., stacking blocks, drawing, cutting, writing)?
Yes_____ No_____

If yes, please explain____

Patient Name:

DOB:

MRN:

PARENT QUESTIONNAIRE

MEDICAL HISTORY

Normal Pregnancy and Delivery: Yes_____ No_____

If no, please describe:____

____

Has your child had any hospitalizations, serious illnesses, or accidents? Yes____ No____

If yes, please explain____

____

Does your child have a history of allergies? Yes____ No____

Does your child have a history of asthma? Yes____ No____

Has your child had frequent ear infections? Yes____ No____

If yes, approximately how many and dates_____________________________________

What type of treatment was rendered for the ear infections (i.e., medication, tubes):

____

Has your child ever had a hearing evaluation?: Yes_____ No_____

If yes, dates, place of testing, and results:_____________________________________

____

Patient Name:

DOB:

MRN:

PARENT QUESTIONNAIRE

SPEECH AND LANGUAGE DEVELOPMENT

Age when child spoke first word:__________ Combined two words:__________

Is there a language other than English spoken regularly in the home: Yes____ No____

If yes, what language(s)?____

What specific concerns do you have about your child's speech and language skills and when did you first note the problem?

____

____

____

Do your child's pediatrician and/or teacher have concerns about his/her speech/language skills?

Yes _______ No ________

If yes, please explain:____

____

____

How well does your child comprehend language?

Oral Directions:

_____ Follows one simple direction
_____ Follows 2-3 directions at a time
_____ Does not seem to understand

Listening to Stories:

_____ No interest
_____ Seems interested but for a short time
_____ Enjoys stories and talks about pictures

PARENT QUESTIONNAIRE

Patient Name:

DOB:

MRN:

SPEECH AND LANGUAGE DEVELOPMENT (Cont.)

Answering Questions:

_____ Responds to yes/no questions
_____ Responds to "Wh" questions
_____ Does not respond

How well does your child express himself/herself?

Sentence length____

Is your child able to communicate needs? Yes_____ No_____

If yes, how?
_____ Orally
_____ With gestures/pointing
_____ Both

Is your child able to tell a story? Yes_____ No_____

Is your child able to maintain a topic or conversation? Yes_____ No_____

Any concerns regarding use of language for social purposes? Yes_____No_____

If yes, please describe:____

____

How well does your child pronounce sounds?

_____ Easy to understand
_____ Family can understand but others cannot
_____ Hard to understand

Do you have concerns regarding your child's voice (pitch, quality, rate, volume)?
Yes_____ No_____

If yes, please describe:____

____

PARENT QUESTIONNAIRE

Patient Name:

DOB:

MRN:

SPEECH AND LANGUAGE DEVELOPMENT (Cont.)

Does your child become frustrated when trying to communicate?

Yes_____ No_____

If yes, please explain:____

____

____

Has your child had a previous speech and language evaluation? Yes____ No____

If yes, please identify who did the evaluation(s) and the date_______________________

____

Has your child had previous speech and language therapy? Yes_____ No_____

If yes, please identify where therapy was conducted and the date___________________

____

Is your child currently on an Individualized Educational Plan (IEP) through the school system? Yes_____ No_____

Any other concerns (i.e., activity level, behavior, general development, tantrums?)
Yes_____ No_____

If yes, please explain:
____

____

____

Thank you for taking the time to fill out this questionnaire. This information will help us in completing a thorough evaluation of your child.

The Speech/Language Pathology Department
Emerson Hospital