Date completed _____

Speech and Language Parent Questionnaire
for
Children 12 months – 4 years old

Child's Name: _____ Birth Date:_____

Parent(s) Name(s): _____ Pediatrician: _____

_____

Address: _____

_____

Email Address:_____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

****Please asterisk(*) the best number where we may reach you.***

How did you hear about us?

☐ Pediatrician or other Professional

☐ Family/Friend referral:_____

☐ Found you online (indicate which site):

☐ Parenting Magazine

☐ Drive By

☐ Other:_____

☐ ☐ Listening Ears, llc.

1. Indicate any concerns you have for your child in the following area(s):

☐ Articulation	☐ Not talking yet	☐ Poor Memory
☐ Receptive Language	☐ Limited number of words	☐ Colors/shapes
☐ Expressive Language	☐ Not putting words together	☐ Letters/numbers
☐ Social Skills	☐ Basic concepts	☐ Word finding
☐ Auditory Processing	☐ Feeding difficulties	☐ Attention/focus
☐ Stuttering	☐ Following simple directions	☐ Behavior

2. When did you first notice the problem(s) you indicated above?

3. Does anyone else in your family have a speech, language, hearing or learning problem?

☐ Yes ☐ No

If *yes*, please describe.

Health and Developmental History

4. Did you have a normal pregnancy? ☐ Yes ☐ No

Length of pregnancy _____

Please list any complications:

5. Medications used during pregnancy:

6. Describe your child's delivery and birth.

☐typical ☐spontaneous ☐induced ☐Cesarean ☐breech ☐unusually long labor

Please list any complications:

7. Duration of labor:

8. Medications used during labor:

9. What was your child's birth weight? _____ APGAR score _____

10. What was your child's condition at birth?

☐typical ☐birth injury/defect ☐jaundiced ☐breathing problem ☐low birth weight ☐other _____

11. Does your child have a history of any of the following? (Check all that apply.)

☐ drooling	☐ ear tubes	☐ intubation/ventilator
☐ chronic ear infections	☐ surgery	☐ hospitalization
☐ allergies	☐ chronic or severe illness	☐ seizures

☐ asthma ☐ high or prolonged fevers ☐ head injury

☐ hearing loss ☐ reflux ☐ serious accidents

Please explain any of the above as needed.

12. Has your child ever been hospitalized? How long?

13. List any medication(s) your child is currently taking.

14. What vaccinations has your child had and when did he/she receive them? Adverse reactions?

15. Has your child ever had a hearing evaluation?

☐ Yes ☐ No

If *yes,* list dates and results.

16. Does your child have a history of feeding problems?
If *yes*, circle all that apply.

☐ choking ☐ difficulty biting ☐ overstuffing mouth

☐ poor nursing ☐ difficulty chewing ☐ difficulty swallowing

17. Does your child have trouble sleeping through the night?

☐ Yes ☐ No

18. Is your child a messy or picky eater?

☐ Yes ☐ No

Please list favorite foods.

Please list food sensitivities:

19. At what age did your child attain these developmental milestones?

sitting _____

first words _____

walking _____

crawling (Please also indicate if there was minimal time spent in the crawling phase) _____

toilet training_____

first sentences_____

20. Handedness:

☐right-handed ☐left-handed ☐ambidextrous

Please also indicate if your child had taken a long time choosing a dominant hand:

Speech and Language

21. Did your child babble? ☐ Yes ☐ No

If *yes,* did he/she use a variety of sounds when babbling? ☐ Yes ☐ No

22. What were your child's first words?

23. Once your child started to use words, did he/she continue to add new words to his/her speaking vocabulary on a weekly basis? ☐ Yes ☐ No

24. Does your child have a history of using a word once or several times, and then never using it again?

☐ Yes ☐ No

If *yes,* please give examples.

25. Is your child reluctant to communicate or become frustrated when trying to speak?

☐ Yes ☐ No

If *yes,* please describe.

26. Is your child reluctant to imitate speech sounds or words? ☐ Yes ☐ No

27. Does it seem that your child has more difficulty producing understandable speech on some days and not others, or at certain times? ☐ Yes ☐ No

If *yes,* please describe.

28. How would you describe your child's speech errors?

☐ consistent ☐ change from word to word and/or day to day

29. Approximately how much of your child's speech do you understand?

☐less than 25% ☐25% ☐50% ☐75% ☐100%

30. Can people outside the family understand your child's speech?

☐ Yes ☐ No

31. How would you describe the intonation and rhythm of your child's speech? (Check all that apply.)

☐smooth	☐slow	☐soft
☐halting	☐fast	☐lacking in intonation
☐choppy	☐loud	☐lacking in pitch changes

32. How does your child typically communicate with others? (Check all that apply.)

☐talking (whether understandable or not)	☐facial expressions
☐gestures	☐pulling/taking adult to what he/she wants
☐signs	☐crying
☐pictures	☐pointing
☐Voice output speech device	Other_____

33. Does your child play and communicate well with his/her friends and family?

☐ Yes ☐ No

34. Does your child seem to understand most of what you say or tell him/her to do?

☐ Yes ☐ No

35. Does your child have difficulty following directions?

☐ Yes ☐ No

If *yes*, please describe.

36. How many words does your child now use?

☐0-20 ☐20-50 ☐100-150 ☐150-200 ☐More than 200

37. If your child uses phrases and sentences, how long are they on average?

☐2 words ☐3 words ☐100-150 ☐4 words ☐longer than 5 words

38. Does your child…? (check *yes* or *no* for each)

	yes	no
ask questions to gain information……..	☐	☐
understand vocabulary…….	☐	☐
use age-appropriate vocabulary…….	☐	☐

stay on subject in a conversation……...☐ ☐

take turns when talking to someone……..☐ ☐

describe and explain……☐ ☐

answer questions……..☐ ☐

have difficulty putting words together into a sentence……☐ ☐

leave words out of sentences……☐ ☐

use correct grammar such as plurals, verb tenses, pronouns…….☐ ☐

39. What have you done in the past to help your child communicate? Is it effective?

Voice and Fluency

40. Is your child's voice clear? ☐ Yes ☐ No
    If *no*, please describe.

41. Describe your child's voice. (Check all that apply.)

☐nasal	☐soft	☐monotone
☐denasal (sounds like he/she has a cold)	☐high-pitched	☐breathy
☐loud	☐low-pitched	☐hoarse

42. Does your child talk smoothly without repeating sounds or words? ☐ Yes ☐ No

    If *no*, does he/she have trouble getting words out? ☐ Yes ☐ No
    If *yes*, please describe.

Sensory and Motor

43. Does your child have any difficulty walking, running, sitting or other large motor skills?

    ☐ Yes ☐ No
    If *yes*, please describe.

44. Does your child tippy-toe walk?

    ☐ Yes ☐ No

45. Is your child clumsy or does he/she fall easily?

☐ Yes ☐ No

46. Does your child have low body tone?

☐ Yes ☐ No

47. Does your child have difficulty with fine motor skills such as stacking, cutting and handwriting?

☐ Yes ☐ No

If *yes*, please describe.

48. Is your child sensitive to certain textures of food or clothing?

☐ Yes ☐ No

If *yes*, please describe.

49. Does your child dislike having substances on his/her hands such as glue or dirt?

☐ Yes ☐ No

50. Is your child oversensitive to being touched or dislike being touched?

☐ Yes ☐ No

If *yes*, please describe.

51. Check all that apply regarding your child.

☐dislikes washing his/her face or hair

☐dislikes haircuts

☐spends too little time or too much time brushing his/her teeth

☐does not demonstrate caution

☐puts things in his/her mouth besides food

☐chews on his/her clothes

Behavior

52. Does your child typically display any of the following behaviors? (Check all that apply.)

☐reduced or lack of interaction with others

☐tantrums

☐passive in interactions

☐very active

☐underactive

☐inattentive

☐refuses to perform tasks

☐difficulty staying on task

☐difficulty finishing tasks

☐sensitive

☐angry/acting out behavior

☐frustrated

☐shy

Other Information

53. Who does your child live with? (Check all that apply.)

☐both parents ☐grandparents

☐mother only ☐foster parents

☐father only ☐other_____

☐parent + stepparent

54. Are languages other than English spoken in the home?

☐ Yes ☐ No

If *yes*, please list.

55. Has your child had a previous speech-language evaluation?

☐ Yes ☐ No

If *yes*, please list date(s) and results.

56. Has your child had previous speech-language therapy?

☐ Yes ☐ No

If *yes*, please list dates, setting(s) and therapist(s).

57. If your child had speech-language therapy, what kind of progress did your child make?

☐ Yes ☐ No

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58. Has your child been evaluated by any other professional? (Check all that apply.)

☐occupational therapist (OT) ☐educator/teacher

☐physical Therapist (PT) ☐geneticist

☐neurologist ☐physician

☐developmental pediatrician (specialist) ☐other_____

☐psychologist/psychiatrist

59. Does your child have a diagnosis from any of the above professionals?

☐ Yes ☐ No

If *yes*, please list date, professional, and diagnosis for each.

60. What other concerns do you have about your child?

61. What do you consider to be your child's greatest strengths?

62. What do you hope to gain from this evaluation?