



## Speech-Language and Learning Parent Questionnaire for Children 5 and above

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

Parenting Magazine

Family/Friend referral: \_\_\_\_\_

Drive By

Found you online (indicate which site):

Other: \_\_\_\_\_



Listening Ears, llc.

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

Articulation

Reading fluency

Poor Memory

Receptive Language

Reading comprehension

Attention/concentration

Expressive Language

Spelling

Loses place/skips lines

Social Skills

Writing

Reversals or letters

Auditory Processing

Math

Motivation/behavior

Slow working

General learning

Over-active

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

3. Does anyone in your family history have a speech, language, hearing or learning problem that you are aware of?

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.)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> drooling               | <input type="checkbox"/> ear tubes                 | <input type="checkbox"/> intubation/ventilator |
| <input type="checkbox"/> chronic ear infections | <input type="checkbox"/> surgery                   | <input type="checkbox"/> hospitalization       |
| <input type="checkbox"/> allergies              | <input type="checkbox"/> chronic or severe illness | <input type="checkbox"/> seizures              |
| <input type="checkbox"/> asthma                 | <input type="checkbox"/> high or prolonged fevers  | <input type="checkbox"/> head injury           |
| <input type="checkbox"/> hearing loss           | <input type="checkbox"/> reflux                    | <input type="checkbox"/> 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.

- |                                       |   |  |
|---------------------------------------|---|--|
| <input type="checkbox"/> choking      | <input type="checkbox"/> difficulty biting  | <input type="checkbox"/> overstuffing mouth    |
| <input type="checkbox"/> poor nursing | <input type="checkbox"/> difficulty chewing | <input type="checkbox"/> difficulty swallowing |

17. Does your child have a history of 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:

## Voice and Fluency

21. Is your child's voice clear?  Yes  No

If *no*, please describe.

22. Describe your child's voice. (Check all that apply, if any.)

nasal

soft

monotone

denasal (sounds like he/she has a cold)

high-pitched

breathy

loud

low-pitched

hoarse

23. 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.

## Auditory Processing and Learning

24. Does your child have difficulty with any of the following? (Check all that apply.)

memory tasks

remembering and following multi-step directions

comprehension

putting thoughts together

word retrieval

difficulty learning or using new vocabulary

- |   |  |
|---|--|
| <input type="checkbox"/> hearing difficulties             | <input type="checkbox"/> auditory attention              |
| <input type="checkbox"/> listening with background noise  | <input type="checkbox"/> academic underachievement       |
| <input type="checkbox"/> reading difficulties             | <input type="checkbox"/> hypersensitivity to loud sounds |
| <input type="checkbox"/> spelling/writing difficulties    | <input type="checkbox"/> word-finding difficulties       |
| <input type="checkbox"/> phonologic/phonemic difficulties | <input type="checkbox"/> auditory distractibility        |
| <input type="checkbox"/> learning difficulties            | <input type="checkbox"/> organization and planning       |

25. Did your child have difficulty learning early academic skills such as matching, identifying same/different and/or knowing names of colors, shapes, numbers, and letters, spatial awareness words (under, between, next to), days of the week, temporal words (yesterday, tomorrow, next week etc)?

- Yes     No

If yes, please describe.

26. Does your child receive any services at school (IEP or 504 plan) or outside help? List all.

- Yes     No

27. Can your child retell a simple story in sequence?

- Yes     No

28. Can your child identify steps to complete a simple task? (e.g., brushing teeth, setting the table)

- Yes     No

29. Did your child having difficulty learning nursery rhymes or the concept of rhyming?

- Yes     No

30. Does your child appear to attend to your face when listening?

- Yes     No

31. Does your child appear to become distracted easily when listening?

- Yes     No

32. Does your child appear to be confused with listening?

Yes     No

33. Does your child appear to be particularly uncomfortable in noise (as compared to age-peers)?

Yes     No

## **Sensory and Motor**

34. Does (or did) your child have any difficulty walking, running, sitting or with any other large motor skills?

Yes     No

If yes, please describe.

Does (or did) your child tippy-toe walk?

Yes     No

35. Is (or was) your child clumsy or does he/she fall easily?

Yes     No

36. Does (or did) your child have low body tone?

Yes     No

37. Does (or did) your child have difficulty with fine motor skills such as stacking, cutting and handwriting?

Yes     No

If yes, please describe.

38. Is (or was) your child sensitive to certain textures of food or clothing?

Yes     No

If yes, please describe.

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

Yes     No

40. Is your child oversensitive to being touched/dislikes being touched?

Yes     No

If yes, please describe.

41. Check all that apply regarding your child, if any.

- |   |  |
|---|--|
| <input type="checkbox"/> dislikes washing his/her face or hair                          | <input type="checkbox"/> does not demonstrate caution              |
| <input type="checkbox"/> dislikes haircuts  | <input type="checkbox"/> puts things in his/her mouth besides food |
| <input type="checkbox"/> spends too little time or too much time brushing his/her teeth | <input type="checkbox"/> chews on his/her clothes                  |

## Behavior

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

- |   |   |
|---|---|
| <input type="checkbox"/> reduced or lack of interaction with others | <input type="checkbox"/> difficulty staying on task |
| <input type="checkbox"/> tantrums                                   | <input type="checkbox"/> difficulty finishing tasks |
| <input type="checkbox"/> passive in interactions                    | <input type="checkbox"/> sensitive                  |
| <input type="checkbox"/> very active                                | <input type="checkbox"/> angry/acting out behavior  |
| <input type="checkbox"/> underactive                                | <input type="checkbox"/> frustrated                 |
| <input type="checkbox"/> inattentive                                | <input type="checkbox"/> shy                        |
| <input type="checkbox"/> refuses to perform tasks                   |   |

## Other Information

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

- |  |   |
|--|---|
| <input type="checkbox"/> both parents        | <input type="checkbox"/> grandparents   |
| <input type="checkbox"/> mother only         | <input type="checkbox"/> foster parents |
| <input type="checkbox"/> father only         | <input type="checkbox"/> other _____    |
| <input type="checkbox"/> parent + stepparent |   |

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

- Yes     No

If yes, please list.

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

- |  |   |
|--|---|
| <input type="checkbox"/> speech-language pathologist             | <input type="checkbox"/> educator/teacher |
| <input type="checkbox"/> occupational therapist (OT)             | <input type="checkbox"/> neurologist      |
| <input type="checkbox"/> physical therapist (PT)                 | <input type="checkbox"/> physician        |
| <input type="checkbox"/> developmental pediatrician (specialist) | <input type="checkbox"/> geneticist       |
| <input type="checkbox"/> psychologist/psychiatrist               | <input type="checkbox"/> other _____      |

46. Has your child had previous Speech-Language Therapy, Occupational Therapy or Physical Therapy?

Yes     No

If yes, please describe duration and outcome of the therapy.

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

Yes     No

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

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

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

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