SPEECH-LANGUAGE QUESTIONNAIRE

Child's Name _____ Date of Birth _____ Age _____ Gender _____

Home Address _____ City _____

Postal Code _____ Home Phone _____

Name of person completing questionnaire _____

Father's Name_____ Home # _____ Cell # _____

Address (if different from above) _____

Mother's Name _____Home # _____ Cell # _____

Address (if different from above)_____

Child's Doctor's/Pediatrician _____

Email _____

FAMILY HISTORY

Siblings/Ages:

_____

Language(s) spoken at home:

_____

Please provide information below if there is current or past history of speech language difficulties in the family

Name/Relation	Describe any speech/language difficulties

REASON FOR SPEECH-LANGUAGE THERAPY:

Please describe: _____

_____

_____

MEDICAL HISTORY

Describe any concerns during pregnancy /birth: _____

_____

Describe any concerns as newborn/toddler: _____

_____

Describe any difficulties with eating/drinking/swallowing: _____

_____

Hearing screen? Yes □ No □ Date:_____

Findings: _____

DEVELOPMENTAL MILESTONES

What age did your child crawl? _____ Walk? _____

What age did your child say his/her first word? _____

What age did your child start putting 2-3 words together? _____

SPEECH AND LANGUAGE

Please check all the statements that describe your child's speech/language at this time:

□ Understands familiar words

□ Follows simple directions

□ Follows 2-3 step directions

□ Understands everything said to him/her

□ Gestures (points, pulls you)

□ Uses few words

□ Uses 2-3 word phrases

□ Uses full sentences

□ Has difficulty pronouncing some sounds

□ Stutters

Provide some examples of what he/she says or how they communicate:_____

_____

Is your child aware of his difficulties? Yes □ No □

Please describe: _____

SOCIAL DEVELOPMENT

Do you any concerns you have about your child's behaviour: □ Yes □ No

How would you describe your child?

□ Generally happy □ Impulsive

□ Good attention □ Easily frustrated

□ Very Active □ Poor attention

Describe what your child likes to play with?

_____

_____

_____

How well does your child play with other children?

_____

_____

_____

Does your child attend a preschool/school? Yes □ No □

If yes please provide Name of preschool/school:

_____

_____

_____

Has the preschool/school raised any concerns? Yes □ No □

If so please describe

_____

_____

_____

OTHER SERVICES

Name of Service/Specialist	Date	Finding

Please provide any additional information that you may think is important for us to know _____

_____

_____

I have voluntarily provided this information. I understand that this information will be used for the purpose of assessing and providing therapy for my child and that it will be kept confidential.

Signature _____

Print Name _____

Date _____