The Speech Dynamic

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# Parent Questionnaire

Date: _____

**General Information:**

Child's Name: _____ Birthdate: _____ Age: _____

Parent/Guardian(s) Name(s): _____

Siblings & Ages: _____

Address: _____ Email: _____

Home #:_____ Work #:_____ Cell #:_____

Parent(s) Occupations(s): _____

Are there other adults in the home? If so, whom: _____

Have other siblings or family members experienced speech/language difficulties? If so, whom:

_____

What language(s) is/are spoken in the home?_____

In case of emergency, notify (other than the adult coming to the sessions):

_____Phone: _____

Physician: _____ Dentist: _____

Orthodontist: _____ Other Therapist: _____

Other Doctor: _____ Referred by: _____

**Statement of Problem:**

Describe your child's speech/language/auditory/orthodontic problem: _____

_____

When was the problem first noticed: _____

How has problem changed/evolved? _____

What strategies have been used at home that seem to help: _____

_____

What professional services has your child received & when: _____

If testing has been done, what skills were assessed? _____

**Speech, Language and Hearing History:**

As an infant, did your child babble and play with sounds? _____

When did your child speak his/her first word? _____

When did s/he begin use to use 2-word phrases? _____

Does s/he use speech Always _____ Occasionally _____ Never _____

Does s/he prefer to use gestures? If so, give examples: _____

Describe your child's speech: Sentences _____ Phrases _____ 1-2 words _____ Sounds _____

Examples: _____

How well can your child be understood by parents (use percentage): _____

by siblings _____ by friends or playmates _____ by strangers _____

Describe your child's auditory behavior (hearing speech and environmental sounds, following directions , etc.): _____

Has speech/language been tested in the last 6 months? By whom? _____

Has hearing been tested in the past year? By whom? _____

Has vision been tested in the past year? By whom? _____

**Social/Behavior:**

Does your child:

Make eye contact _____

Respond on topic _____

Interrupt appropriately _____

Stay on topic _____

Tell you the names of things _____

Tell you how things are used _____

Describe things and actions _____

Ask for information _____

Give information _____

Make requests _____

Apologize _____

Protest _____

Show humor _____

Solve problems verbally _____

Greet people _____

Is your child:

Competitive _____

Sensitive to criticism _____

Perfectionist _____

Mature for age _____

Overly sensitive to touch _____

Overly sensitive to sound _____

Other:_____

What are your child's favorite play activities? _____

_____

Does your child play alone or with other children? _____

How does s/he get along with other children? _____

How does s/he get along with adults? _____

Is it difficult to discipline your child? _____

How would you describe your child? _____

**Birth and Developmental Information:**

Age of parents at child's birth: Mother_____ Father _____

Is this an adopted child? _____ Child's age at adoption _____

Mother's health during pregnancy: _____

Full term child?_____ If no, # of weeks gestation at birth: _____

Birth weight? _____ Describe delivery: _____

Birth injury?_____ Jaundiced? _____ Oxygen required?_____

Heart murmur? _____ Nursing difficulty? _____

Child's health during first several months: _____

Any significant childhood illnesses, injuries, or abnormalities? _____

_____

Indicate ages at which your child accomplished the following:

Sat alone: _____ Stood alone: _____ Crawled: _____

Walked alone: _____ Bowel trained: _____ Bladder trained: _____

Dressed self: _____

Was child's rate of growth seemingly normal? _____

Was normal development interrupted by anything? _____

Does your child have difficulty with gross or fine motor tasks? _____

**Feeding History:**

Was child breast-fed or bottle-fed? _____

If breast-fed, how long? _____ If bottle-fed, how long? _____

Were there early feeding problems such as colic, special formula, or difficulty making the transition to table food? _____

Does s/he drink more than one glass of liquid with meals? _____

Does s/he appear to wash down food? _____ Is s/he a fast or slow eater? _____

Does s/he chew food adequately? _____ Does s/he belch excessively? _____

Does s/he have frequent digestive problems? _____ Does s/he choke easily? _____

Does s/he resist foods that are difficult to chew? _____

Does s/he eat a variety of foods, textures, temperatures, flavors? _____

_____

Is s/he on a special diet? Describe: _____

**Medical History:**

*Age* *Severity*

Tonsillitis: _____

Tonsillectomy: _____

Adenoidectomy: _____

Lingual Frenectomy: _____

Middle Ear Infections: _____

Earaches: _____

Ear Surgery: _____

Hearing Loss: _____

Heart Problems: _____

High Fevers/Measles: _____

Mumps: _____

Pneumonia: _____

Frequent Colds: _____

Upper Respiratory Infections: _____

Snoring: _____

Allergies: _____

Asthma: _____

Sinus Problems: _____

Headaches: _____

Seizures: _____

Head Injury: _____

Loss of Consciousness: _____

GERD (Acid Reflux): _____

Visual difficulty: _____

Is your child currently under a physician's care? For: _____

Is your child taking any medications? _____

Other medical conditions not mentioned: _____

Is there smoking in the home? _____

Is general health good? _____

Other injuries or surgeries?_____

**Dental History:**

Has your child ever sucked thumb/fingers: _____ Until what age: _____

Did your child use a pacifier: _____ Until what age: _____

Were baby teeth normal? _____Were baby teeth lost at normal ages?_____

Were baby teeth lost to accident or injury? _____

Does your child have cavities or periodontal disease: _____

How often does your child brush teeth daily? _____ Flossing per week? _____

Does anyone in your family have similar dental conditions: _____

Does your child clench or grind teeth at night: _____ Day: _____

Does your child have any pain or clicking upon closing the mouth: _____

opening widely: _____ chewing: _____ Any other facial pain: _____

Does your child have difficulty chewing, eating, and/or swallowing food: _____

Does your child often have headaches: _____ Any severe facial injuries: _____

Have permanent teeth been injured/chipped/lost: _____ Extra teeth: _____

Which teeth and when: _____

If your child has seen an orthodontist, what has been done so far? _____

Any orthodontic appliances in currently in place? _____

Are adjustments still being made? _____ When will appliance come off? _____

What does the orthodontist plan to do in the future? When? _____

If orthodontic treatment is completed, how long were braces worn? _____

How long ago were braces removed? _____ What kind of retainer is worn? _____

Has occlusion gotten better, worse, or stayed the same during the last 6-12 months? _____

What other family members had: orthodontic treatment? _____

treatment for feeding, swallowing, or tongue thrust issues? _____

**Associated Oral Behaviors:**

Does your child breath through mouth, nose, or both? _____

Is mouth open or closed while watching TV, riding in car, or sleeping? _____

Does s/he bite fingernails? _____ Does s/he chew on pencils, shirt, etc? _____

Does s/he lick lips excessively? _____ Are lips chapped much of the time? _____

Does s/he prop chin on palm or fist? _____ Does s/he chew gum excessively? _____

**Educational Information:**

School: _____Grade: _____

Address: _____ Teacher's Name: _____

Does child excel in any subjects/areas? _____

Does s/he struggle in any subjects/areas?_____

Does s/he read at grade level? _____ Does s/he enjoy reading? _____

Does s/he spell at grade level? _____ Does s/he enjoy writing? _____

How does your child feel about school and his/her teachers? _____

_____

Is/Has your child been in any special programs (Speech, Language, Reading, Special Ed., etc.):

_____

If so, Teacher's/SLP's Name(s): _____

**Other Factors:**

If you were to indicate factors that may be related to your child's problem, which ones would you include? Circle as many factors as you think are important.

Anxiety/Nervousness
Autism
Behavior Problem
Birth Injury/Trauma
Brain Injury
Cerebral Palsy
Difficulties with Attention
Emotional
Environmental Problems
Epilepsy
Family Trauma
Feeding Problems
Genetics/Heredity
Hearing Loss
Inconsistency in Parenting
Lack of Playmates
Mental Retardation
Neglect by Father
Neglect by Mother
Overprotection by Father
Overprotection by Mother
Recent Move
Sensory Integration
Shyness
Sibling Rivalry
Slow Development
Stubbornness
Visual Disturbances

Related Comments: _____

**Questions & Additional Information:**

Are there specific questions you would like answered about your child?

Is there anything else about your child or your family that I should know that might help me provide better service?