



# **GREATER ATLANTA SPEECH AND LANGUAGE CLINICS, INC.**

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## **CONFIDENTIAL PARENT QUESTIONNAIRE FOR SPEECH/LANGUAGE & HEARING EVALUATION**

(All information provided is strictly confidential and will not be provided to any other agency without your written consent.)

Child's Name: \_\_\_\_\_ Evaluation Date: \_\_\_\_\_

Child's Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status of Parents: \_\_\_\_\_

Referred to clinic by: \_\_\_\_\_

### **I. GENERAL INFORMATION**

1. Describe what concerns you have about your child's development: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. When did you first notice this problem? \_\_\_\_\_

\_\_\_\_\_

3. List other professionals who have evaluated your child and any diagnosis made (include dates):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Has your child received any previous treatment for this specific problem? \_\_\_\_ yes \_\_\_\_ no

5. If yes, where/when: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

6. Is a second language spoken in the home? \_\_\_\_\_ Is so, what language? \_\_\_\_\_

7. Please list brothers and/or sisters of the child and their ages:

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8. Please list other persons living in your home, their ages, and relationship to child:

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9. What do you hope to learn from this evaluation and what specific questions do you have or areas do you wish to address? \_\_\_\_\_

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**II. DEVELOPMENTAL HISTORY**

**A. Prenatal:**

1. How was the health of the mother during this pregnancy? \_\_\_\_\_

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2. Any accidents or illnesses? \_\_\_\_\_ If so, please explain briefly: \_\_\_\_\_

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3. Has the mother had any problems with other pregnancies before or after this? \_\_\_\_\_ If so, please explain: \_\_\_\_\_

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4. Please check any conditions that applied to the mother during this pregnancy:

\_\_\_\_ Nervous & apprehensive \_\_\_\_ RH negative \_\_\_\_ Unusually happy \_\_\_\_ Moody \_\_\_\_ Headaches

\_\_\_\_ High blood pressure \_\_\_\_ Virus infections \_\_\_\_ German Measles \_\_\_\_ Toxic condition

\_\_\_\_ Bed rest or hospitalization \_\_\_\_ Use of Pitocin or Breathine

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

5. If mother had German Measles (Rubella) or was exposed to it, please give month in which it occurred (first, second, third, etc.): \_\_\_\_\_

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6. If virus infections, give type and month occurred: \_\_\_\_\_

7. Did the mother take any medication or drugs during this pregnancy? \_\_\_\_\_ If so, what? \_\_\_\_\_

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B. Peri-natal:

1. Weight of child at birth: \_\_\_\_\_ pounds, \_\_\_\_\_ ounces
  2. Duration of pregnancy: \_\_\_\_\_ months
  3. Was there false labor? \_\_\_\_\_
  4. How long was labor? \_\_\_\_\_
  5. How long before delivery did water break? \_\_\_\_\_
  6. Were instruments used? \_\_\_\_\_ If so, what? \_\_\_\_\_
  7. What kind of anesthesia was given to the mother? \_\_\_\_\_
  8. Was the delivery: \_\_\_ Spontaneous \_\_\_ Induced \_\_\_ Cesarean Section \_\_\_ Breech
  9. Was there anything unusual in the baby's condition at birth or soon after, such as:  
\_\_\_\_ Injury    \_\_\_\_ Paralysis    \_\_\_\_ Cord wrapped around neck    \_\_\_\_ Bruises  
\_\_\_\_ Coloring (blue or yellow)    \_\_\_\_ Other (explain): \_\_\_\_\_
  10. Was the baby given blood transfusions or exchanges at birth? \_\_\_\_\_
  11. Was the baby given oxygen? \_\_\_\_\_
  12. Were there any problems after birth? \_\_\_\_\_ Such as: \_\_\_ Feeding problems \_\_\_\_\_ Seizures \_\_\_\_\_  
Other Illness: (explain) \_\_\_\_\_
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**III. MOTOR DEVELOPMENT**

1. At what age did the child do the following?

_____ Head support	_____ Drink from a cup
_____ Sit alone	_____ Pull off his socks
_____ Crawl	_____ Eat with spoon
_____ Walk alone	_____ Ask to go to the toilet

2. Does the child:

_____ Prefer the right or left hand?	_____ Have a peculiar walk?
_____ Fall, lose balance easily	_____ Seem awkward and uncoordinated?
_____ Have difficulty chewing and/or swallowing?	_____ Grasp objects readily?

**IV. FEEDING HISTORY**

1. Does or did your child have any difficulty with the following:

- |  |  |
|--|--|
| <input type="checkbox"/> Sucking/nursing                     | <input type="checkbox"/> Regurgitation of liquids or solids through nose |
| <input type="checkbox"/> Transition from bottle to baby food | <input type="checkbox"/> Difficulty chewing or swallowing                |
| <input type="checkbox"/> Choking or gagging                  | <input type="checkbox"/> History of aspiration                           |
| <input type="checkbox"/> Reflux                              | <input type="checkbox"/> Tube feeding (NG, OG, or g-tube)                |

2. Is your child a picky eater:  yes  no If "yes" what food does he/she prefer?  
\_\_\_\_\_  
\_\_\_\_\_

3. Does your child prefer or avoid food textures?  Explain: \_\_\_\_\_  
\_\_\_\_\_

4. Does your child drool excessively for his/her age?  yes  no

**V. PLAY BEHAVIORS**

1. Does your child enjoy or do the following:

- |  |  |
|--|--|
| <input type="checkbox"/> Looking at books      | <input type="checkbox"/> Put toys in mouth         |
| <input type="checkbox"/> Rough and tumble play | <input type="checkbox"/> Bang toys together        |
| <input type="checkbox"/> Role playing          | <input type="checkbox"/> Act out familiar routines |
| <input type="checkbox"/> Make-believe play     | <input type="checkbox"/> Use objects appropriately |
| <input type="checkbox"/> Games with rules      |  |

**VI. HEALTH HISTORY**

1. Check any illnesses the child has had. Specify information, such as age, degree of temperature, medical treatment received:

- |                      |                                  |
|----------------------|----------------------------------|
| _____ Measles        | _____ Meningitis                 |
| _____ Whooping Cough | _____ Poliomyelitis              |
| _____ Scarlet Fever  | _____ Encephalitis               |
| _____ Influenza      | _____ Epilepsy                   |
| _____ Chicken Pox    | _____ Convulsions/ Seizures      |
| _____ Mumps          | _____ Falls or blows to the head |
| _____ Tonsillitis    | _____ Frequent Ear Infections    |
| _____ Allergy        | _____ Frequent Colds             |
| _____ Pneumonia      | _____ Bronchitis                 |
| _____ Asthma         |                                  |

2. If you child has had more than one ear infection, how old was the child when the ear infections occurred?

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3. How were the ear infections treated (antibiotics, tube, etc.)?

Check any surgery your child has had. Specify date of surgery, where, duration of hospitalization, and attending physician:

\_\_\_\_\_ Tonsillectomy \_\_\_\_\_

\_\_\_\_\_ Adenoidectomy \_\_\_\_\_

\_\_\_\_\_ Ear Surgery, any type \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

3. Is the child presently on medication? \_\_\_\_\_ If so, specify by name and reason prescribed:

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4. Has the child ever taken streptomycin, neomycin, quinine, dihydrostreptomycin, or kanamycin?

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5. Are there any members of the family who have hearing or speech difficulties? \_\_\_\_\_ If so, please specify who and what the difficulty was: \_\_\_\_\_

6. Does any member of the family have similar problems that the child has? \_\_\_\_\_

7. Is child allergic to food, drink, insect bites, etc: \_\_\_\_\_ Explain: \_\_\_\_\_

**VII. EMOTIONAL ADJUSTMENT** (please write "yes" or "no")

1. Is the child:

2. Does or did the child:

- \_\_\_ Responsive to people
- \_\_\_ Most responsive to objects
- \_\_\_ Especially alert to movements
- \_\_\_ Sensitive to vibratory sensations
- \_\_\_ Sensitive to being touched
- \_\_\_ Highly distractible, hyperactive
- \_\_\_ Behavior consistent from day to day
- \_\_\_ Playful with children, adults, pets

- \_\_\_ Eat well
- \_\_\_ Sleep well
- \_\_\_ Make his wants known
- \_\_\_ Cry, sob, shed tears
- \_\_\_ Show concern when separated from parents
- \_\_\_ Laugh, smile, seem happy
- \_\_\_ Rock his head in crib, or while sitting or standing
- \_\_\_ "Bang" his head on crib, chair, floor
- \_\_\_ "Stare" at lights, objects, people, into space

**VIII. HEARING**

1. Do you suspect any hearing difficulty? \_\_\_\_\_

2. Has your child's hearing been tested? If yes, When? Where? Results? \_\_\_\_\_

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3. Has your child been diagnosed with a hearing impairment? \_\_\_\_\_ If yes, by whom and when; please describe hearing loss that has been diagnosed: \_\_\_\_\_  
\_\_\_\_\_
4. Do you think he hears your voice? \_\_\_\_\_ How do you know? \_\_\_\_\_
5. Does he know from which direction sounds come? \_\_\_\_\_
6. Does he hear better with one ear than the other? \_\_\_\_\_
7. Which ear does he use on the telephone? \_\_\_\_\_
8. Is the child especially alert to lip movement, body movement, or vibrations? \_\_\_\_\_
9. How do you get the child's attention when his back is turned away? \_\_\_\_\_
10. Does your child: (Please write "yes" or "no")

- |  |  |
|--|--|
| <input type="checkbox"/> Respond to any sound                          | <input type="checkbox"/> Ask to have words repeated                                    |
| <input type="checkbox"/> Respond to doorbell, airplane, car horn, etc. | <input type="checkbox"/> Seem to hear but not understand                               |
| <input type="checkbox"/> Respond consistently                          | <input type="checkbox"/> Show fear of any sound  |
| <input type="checkbox"/> Ignore sound willfully                        | <input type="checkbox"/> Trained in sign language                                      |
| <input type="checkbox"/> Gesture to communicate                        | <input type="checkbox"/> Wear a hearing aid or ever worn one (If so, what type? _____) |

**IX. AUDITORY PROCESSING**

1. Can your child understand directions/and or conversation: \_\_\_\_ yes \_\_\_\_ no If "no", what behaviors have you observed? \_\_\_\_\_  
\_\_\_\_\_
2. Has your child been diagnosed with an auditory processing disorder? \_\_\_\_ yes \_\_\_\_ no

**X. SPEECH AND LANGAUGE DEVELOPMENT (please write "yes" or "no")**

1. Did, or does, the child (include age when applicable):
 

Age	Age
<input type="checkbox"/> _____ Babble	<input type="checkbox"/> _____ Use jargon (jabber without saying real words)
<input type="checkbox"/> _____ Vocalize for pleasure	<input type="checkbox"/> _____ Communicate by crying, laughing, and smiling
<input type="checkbox"/> _____ Use gestures meaningfully	<input type="checkbox"/> _____ Attempt to imitate speech
<input type="checkbox"/> _____ Never use his voice	<input type="checkbox"/> _____ Unexpectedly understand speech
<input type="checkbox"/> _____ Acquire speech and then stop talking	<input type="checkbox"/> _____ Have a "language of his own"
2. Which is/are his/her most frequent means of communication: \_\_\_\_\_ gestures \_\_\_\_\_ sounds \_\_\_\_\_  
\_\_\_\_\_ words \_\_\_\_\_ phrases \_\_\_\_\_ complete sentences \_\_\_\_\_ looking at objects  
\_\_\_\_\_ pointing to objects \_\_\_\_\_ physical manipulation
3. How old was your child when he/she used his/her first meaningful word, **other than** "mama"/"dada"? \_\_\_\_\_
4. Does he have difficulty pronouncing any sounds? \_\_\_\_\_ If so, which ones? \_\_\_\_\_
5. Can parents understand his speech? \_\_\_\_\_ Relatives? \_\_\_\_\_ Playmates? \_\_\_\_\_ Teachers? \_\_\_\_\_

6. Is your child easily frustrated when he/she is not understood? If so how does he/she express that frustration? \_\_\_\_\_  
\_\_\_\_\_

7. Is your child aware of his/her communication difficulties? \_\_\_\_\_

8. Do you have concerns about your child's voice? \_\_\_\_\_

**XI. EDUCATIONAL HISTORY**

1. Name of school presently attending: \_\_\_\_\_

2. Grade or level: \_\_\_\_\_

3. Describe general progress and behavior in school: \_\_\_\_\_  
\_\_\_\_\_

4. Is the child in special class or receiving tutoring for any reason? If so, specify where and for what reason:  
\_\_\_\_\_

5. Does your child display preference for any learning style over another? \_\_\_ visual \_\_\_ auditory  
\_\_\_ both

**XII. ADDITIONAL PARENT COMMENTS**

Please provide your personal observations relative to the child's speech/language and/or hearing and behavior:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Completed by: \_\_\_\_\_  
Signature

Relationship to client: \_\_\_\_\_

Date: \_\_\_\_\_