



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:

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

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

II. DEVELOPMENTAL HISTORY

A. Prenatal:

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

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

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

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.): _____

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

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

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) _____
-

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 ____ Grasp objects readily?
 swallowing?

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?

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:

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

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? _____

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: _____