FUNctionabilities

Speech Therapy Pre-Exam Questionnaire

In order to evaluate your child's condition fully, please be as accurate as possible. Thank you.

Child's Name: _____ Date of Birth:_____

When was hearing last screened/tested? Date: _____ Results: _____

Primary Language Spoken in the Home: _____

Previous Speech Therapy History
Has your child received speech therapy services in the past? ☐ Yes (Explain below) ☐ No

Family History
Is there history of speech and/or language problems in the immediate or extended family? ☐ Yes (Explain below) ☐ No

Birth and Medical History
Were there any difficulties or complications during pregnancy, at, or shortly after birth? ☐ Yes (Explain below) ☐ No

Use of alcohol, tobacco, or medications during pregnancy: ☐ Yes (Explain below) ☐ No

Full term? ☐ Yes ☐ No If no, how many weeks? _____ Type of birth: ☐ Vaginal ☐ Caesarean

Does your child have allergies? ☐ Yes (Please list below) ☐ No

Current medications:

Any serious or recurring illnesses? ☐ Yes (Explain below) ☐ No

Does your child have any pertinent diagnoses? ☐ Yes (Explain below) ☐ No

List all hospitalizations with dates:

Are there concerns with your child's: vision ☐ Yes (Explain below) ☐ No Dental ☐ Yes (Explain below) ☐ No

Please list any other significant health concerns:

School History
Child's current school and grade level:

Is your child at or above grade level in: ☐ reading ☐ writing

Does your child receive specialized services at school? ☐ Yes (Explain below) ☐ No

Developmental History
Age of your child when the following developmental milestones were met? *(If you don't know ages, indicate if on time or delayed):*

sat unassisted _____ crawled _____ walked _____ toilet trained _____ dressed self _____ fed self _____

used gestures _____ babbled _____ single words _____ combined words _____ sentences _____

Describe your child's sleep patterns:

Present Speech and Language Concerns

Articulation:

Do you have concerns with how your child pronounces words? ☐ Yes (Explain below) ☐ No

How much do you understand of what your child says? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-90% ☐ 90-100%

How much do people outside of your family understand of what your child says? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-90% ☐ 90-100%

Can your child imitate words? ☐ Yes (Explain below) ☐ No

Language:

Does your child communicate verbally? ☐ Yes (Explain below) ☐ No

If yes, do they use: ☐ 1 word phrases ☐ 2-3 word phrases ☐ 4+ word phrases

Does your child:

Follow directions? ☐ Yes ☐ No Attend to books read to him? ☐ Yes ☐ No Point to named pictures in book? ☐ Yes ☐ No

Name pictures in books? ☐ Yes ☐ No Answer yes/no questions? ☐ Yes ☐ No Answer who/what/when/where/why questions? ☐ Yes ☐ No Understand basic concepts? Colors: ☐ Yes ☐ No Letters: ☐ Yes ☐ No Numbers: ☐ Yes ☐ No Shapes: ☐ Yes ☐ No Body Parts: ☐ Yes ☐ No

Social:

Does your child:

Greet others? ☐ Yes ☐ No Speak to other children? ☐ Yes ☐ No Speak to adults? ☐ Yes ☐ No

Make appropriate eye contact when listening and speaking? ☐ Yes ☐ No Play with other children? ☐ Yes ☐ No

Do you have concerns with how your child interacts with peers and adults? ☐ Yes (Explain below) ☐ No

Voice:

Can your child speak in a: Normal volume ☐ Yes ☐ No Whisper ☐ Yes ☐ No Shout ☐ Yes ☐ No

Does your child's voice have a "hoarse" vocal quality at any time? ☐ Yes ☐ No

Fluency:

Does your child ever have difficulty communicating wants/needs due to stuttering? (Repetition of sounds/words, i.e. "I-I-I want to play" or "I w-w-want to play") ☐ Yes (Explain below) ☐ No

Other:

What does your child love doing?

Please describe your child's strengths:

How does your child handle frustration?

Patient Name: _____ Parent/Guardian Signature: _____ Date: _____