



Teaching and Assessing Language for Kids

Speech & Language History
Parent Questionnaire

Person(s) responding _____ Date _____
Relationship(s) to child _____

GENERAL INFORMATION

Child's Name _____ Date of Birth _____ Age _____

Mother's address:

Father's address (if different):

Your child's siblings (name & age): _____

What languages are spoken in the home; which one is the primary language? _____

In your own words, why are you bringing your child in for an evaluation? _____

PROFESSIONAL EVALUATIONS

Has your received any diagnoses (e.g., hearing loss, cerebral palsy, Apraxia, receptive/expressive language delay)? If so, please describe:

Please note current **professionals** working with your child, as well as the approximate **frequency & duration** of these sessions:

Audiologist _____

Speech-Language Pathologist _____

Setting (e.g., school name, clinic/private practice name) _____

Contact information (e.g., email address, phone number) _____

How long has your child been working with this/these SLP(S)? _____

Neuropsychologist _____

Psychologist _____

Psychiatrist _____

Pediatrician _____

Neurologist _____

Ear Nose and Throat Doctor (ENT) _____

Orthodontist _____

Physical Therapist _____

Occupational Therapist _____

Other _____

MEDICAL HISTORY

Were there any abnormal occurrences in your child's pregnancy or delivery? _____

Since birth, has your child experienced any **medical problems** (e.g., hospitalizations, surgeries, diagnoses, feeding difficulties, ear infections) before/during/after birth? If so, please explain. _____

Please describe current **health concerns**, if any (e.g., allergies, illnesses).

List your child's current **medications** (and **dosages**). Please note any positive/negative **effects** of the medication(s).

When was the last time your child's **hearing** was checked? What were the results?

DEVELOPMENT

Indicate the age at which your child demonstrated the following:

Sitting up: _____
Crawling: _____ Cooing: _____
Walking: _____ Babbling: _____
Toilet training: _____ First word: _____

CHILD CARE / EDUCATION

Where does your child currently attend **school/daycare**? How often? Grade? Teachers' names? _____

COMMUNICATION SKILLS

Describe your child's current **expressive language**? What sounds do you notice that he/she has difficulty producing? If he/she is **nonverbal**, please discuss your child's use of signs, gestures (e.g., waving, nodding, hand-pulling), vocalizations/word approximations, and/or augmentative means (e.g., AAC devices, PECS) when communicating. Is he/she aware of his/her difficulty and, if so, how does that affect him/her emotionally or behaviorally?

What is your impression of your child's **receptive language**? Is he/she able to follow directions? Does he/she seem to understand age appropriate vocabulary? Can he/she seem to comprehend age appropriate stories?

What is your impression of your child's **social communication** (i.e., pragmatics)? For example, does he/she use: greetings, eye contact, politeness markers, initiation and turn-taking when playing and interacting, and language (verbal or nonverbal) for a variety of purposes (e.g., to make requests, get information, express emotions)? Please describe your child's ability to establish and maintain peer friendships.

Have there been any noticeable **changes** (positive or negative) in your child's communication behaviors (e.g., expressive language, auditory comprehension, social language) in recent months? If so, explain.

Please describe your child's **play behavior** (e.g., sharing, cooperating with others, pretending, using toys appropriately and symbolically).

Describe your child's **feeding/eating** (e.g., types of foods, sucking/swallowing, sensitivity to textures, picky eating).

Describe your child's fine and gross **motor development** (e.g., gross: running, throwing, jumping; fine: coloring, zipping, cutting).

Describe your child's **temperament/personality** (e.g., how he/she handles frustration, his/her response to affection, needs).

TREATMENT

Has/does your child work with any other speech-language pathologist? What goals were/are targeted?

What **strategies** have been used with your child in the past to facilitate speech/language development, if any? Which seemed to be effective and which did not?

Please describe your child's daily routine (e.g., wakeup time, morning activities, nap time, afternoon activities, bed time).

Please list items of interest to your child that can be used for positive **reinforcement**?

Foods _____

Please note any foods that should be *avoided* _____

Games/Activities _____

Sensory Experiences _____

Other (e.g., cartoon characters) _____

OTHER INFORMATION

Your child's treatment plan is designed to be functional and personally relevant to him or her. Therefore, your child's everyday vocabulary (e.g., people, places, animals) and experiences are incorporated into therapy sessions whenever possible. Please list the items of importance (when applicable) and briefly mention how they are significant in your child's world:

Pets _____

(Extended) Family Members _____

Friends _____

Places (e.g., park, church) _____

Activities (e.g., play groups, sports) _____

Books _____

Songs _____

Other _____

Please note any additional concerns or information to share with TALK.

