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Greater Atlanta Speech and Language Clinics

Working Together for a Greater Tomorrow

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CONFIDENTIAL PARENT QUESTIONNAIRE FOR 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: _____

I. GENERAL INFORMATION

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

   _____

   _____

   _____

2. When did you first notice this problem? _____

3. List any diagnoses your child has and the professional who made the diagnosis (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 other persons living in your home, their ages, and relationship to child:

   _____

   _____

8. 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 virus infections, give type and month occurred: _____

6. 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. Were instruments used? _____ If so, what? _____
4. Was the delivery: ___Spontaneous ____Induced ____Cesarean Section ___ Breech
5. 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): _____

6. Was the baby given blood transfusions or exchanges at birth? _____

7. Was the baby given oxygen? _____

8. Were there any problems after birth? _____ Such as: ____ Feeding problems _____ Seizures _____

   Other Illness: (explain) _____

   _____

9. Was baby released from hospital with the mother? _____ If no, when? _____

III. 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	_____Cardiac Issues
_____Constipation	_____Urinary Tract Infections
_____Other	

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.)? _____

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

   _____ Tonsillectomy _____

   _____ Adenoidectomy _____

   _____ Ear Surgery, any type _____

_____Orthopedic Surgery, any type _____

_____Cardiac Surgery, any type _____

_____ Other _____

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

_____

4. Does any member of the family have similar problems that the child has? _____

   If yes, describe who and what the problem was_____

   _____

5. Is child allergic to food, drink, insect bites, etc: _____ Explain: _____

_____

IV. MOTOR DEVELOPMENT

A. Motor/Sensorimotor

1. At what age did your child:

___	Lift head while on stomach	___	Drink from a straw
___	Roll over front to back	___	Drink from a cup without help
___	Sit alone	___	Use a spoon
___	Crawl on all fours	___	Stop wearing diapers during the day
___	Stand alone	___	Pedal a tricycle
___	Walk holding on to the furniture	___	Ride a bike
___	Walked independently	___	Walk down stairs unassisted
___	Give up a bottle during the night		

2. Please describe any differences you noticed in your child's motor development from other children at the same age: _____

3. Does your child use any assistive equipment? _____ If yes, what type? _____

   _____

4. What movement activities does your child like? _____

   _____

5. What activities does your child avoid? _____

   _____

6. Does your child have issues with muscle tone or range of motion? If yes, describe _____

   _____

7. Does he/she seem overly sensitive to (check):

Begin touched	__	
Being hugged	__	
Having face washed or hair cut	__	
Eating certain foods, flavors or textures	__	(list) _____
Wearing certain clothes	__	(list) _____

8. Does he/she:

   Avoid touching things or getting dirty? _____

   Cover ears or hide head around certain noises? _____

   Blink excessively or blink when a ball is thrown to him/her? _____

9. Can your child throw a ball? _____ Catch a ball? _____

10. Which hand is used most often? _____

11. Do you feel your child's hand skills are delayed? _____

    Please list the hand skills you feel are difficult for him/her to do: _____

    _____

B. Self Help - Please check any of the following your child <u>CAN</u> do.

1. Eating:

___ Suck from a bottle/straw
___ Drink from a cup held for him/her
___ Hold and drink from a cup with sipper top____ Without a top
___ Finger feed
___ Feed self without help
___ Hold a spoon
___ Scoop with a spoon
___ Use a fork
___ Use a knife to spread____/to cut
___ Eats with much spilling ____/little spilling ___/no spilling

Describe any special equipment/help needed:

_____

_____

2. Dressing: (Yes, no, needs help)

Removes:	shoes _____	shirt/jacket _____	pants _____	underpants _____
Puts on:	shoes _____	shirt/jacket _____	pants _____	underpants _____

Describe any help needed: _____

_____

3. Hygiene**:** (Please describe any specific help or special equipment needed with):

Bathing _____

Tooth brushing _____

Toileting _____

C. Psychological and Play

1. Other than TV/computer does your child have difficulty:

   Paying attention? _____

   Sticking to one activity for 2-3 minutes? _____ for 15-20 minutes? _____

2. Does your child:

   Have difficulty switching activities? _____

   Have rituals or need to do things the same way each time? _____

   Become frustrated easily? _____

   Have tantrums? _____ Hit/bite? _____

3. Describe any other behavior problems you have with your child: _____

   _____

4. What disciplinary methods do you use? _____

5. Does your child have many friends? _____

6. Does he/she prefer to play with older children? _____ Younger children? _____ Alone? _____

7. What are your child's favorite play activities toys, games etc.? _____

   _____

8. Does your child have unusual fears? _____ Preoccupations? _____

9. Has he/she had any evaluations for behavioral or emotional problems? _____ If so, by whom and when? _____

10. Please check any terms that apply to your child:

__ Shy	__ Friendly	__ Cooperative	__ Creative
__ Nervous	__ Overly talkative	__ Jealous	__ Thumb sucker
__ Nail biter	__ Destructive	__ Angry	__ Aggressive
__ Ritualistic	__ Rocks	__ Head banger	__ Poor tolerance for change
__ Bites	__ Fidgety	__ Affectionate	__ Short attention span
__ Lazy	__ Overly active	__ Absent minded	__ Lacks self confidence
__ Cuddler	__ Picky eater	__ Poor appeetite	__ Rarely shows emotion
__ Daydreams	__ Avoids eye contact	__ Looks through you	__ Good self esteem

V. FEEDING HISTORY

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

____ Sucking/nursing
____ Transition from bottle to baby food
____ Choking or gagging
____ Reflux
____ Regurgitation of liquids or solids through nose
____ Difficulty chewing or swallowing
____ History of aspiration
____ 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

VI. PLAY BEHAVIORS

1. Does your child enjoy or do the following:

____ Looking at books
____ Rough and tumble play
____ Role playing
____ Make-believe play
____ Games with rules
____ Put toys in mouth
____ Bang toys together
____ Act out familiar routines
____ Use objects appropriately

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

1. Is 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

2. Does or did the child:

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

1. At what age did your child (indicate months or years):

____ Babble
____ Vocalize for pleasure
____ Use gestures meaningfully
____ Never use his voice
____ Acquire speech and then stop talking
____ Use jargon (jabber without saying real words)
____ Communicate by crying, laughing, and smiling
____ Attempt to imitate speech
____ Unexpectedly understand speech
____ 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"? ____ What was the word? _____
4. Does s/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? _____

IX. HEARING/VISION

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? _____ Does he hear better with one ear than the other? _____ How do you get the child's attention when his back is turned away? _____
6. Can your child understand directions/and or conversation: ____ yes ____ no If "no", what behaviors have you observed? _____
7. Has your child been diagnosed with an auditory processing disorder? ____ yes ____ no

8. Does your child: (Please write "yes" or "no")

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

9. Do you suspect any vision difficulty? _____

10. Has your child been diagnosed with a vision impairment? _____ If yes, by whom and when; please describe: _____

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
6. Does your child receive any other therapies? _____

If yes, Please provide therapist names, etc.

Therapist	Type of Therapy	Location	Date began
_____			
_____			
_____			

XII. ADDITIONAL PARENT COMMENTS

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

_____

_____

_____

_____

Completed by: _____ Relationship to client: _____
Signature

Date: _____