1515 Johnson Ferry Road
Suite 100
Marietta, Georgia 30062
Phone: (770) 977-9457
Fax: (770) 977-5087

Greater Atlanta Speech and Language Clinics

Working Together for a Greater Tomorrow

Mindy C. Elkan, M.A., CCC
Clinical Director
Michelle Needle, M.Ed.,CCC
Assistant Director

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 swallowing?	____	Grasp objects readily?

IV. FEEDING HISTORY

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

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

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

__ 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. 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")

___	Respond to any sound	___	Ask to have words repeated
___	Respond to doorbell, airplane, car horn, etc.	___	Seem to hear but not understand
___	Respond consistently	___	Show fear of any sound
___	Ignore sound willfully	___	Trained in sign language
___	Gesture to communicate	___	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	
__	____	Babble	__	____	Use jargon (jabber without saying real words)
__	____	Vocalize for pleasure	__	____	Communicate by crying, laughing, and smiling
__	____	Use gestures meaningfully	__	____	Attempt to imitate speech
__	____	Never use his voice	__	____	Unexpectedly understand speech
__	____	Acquire speech and then stop talking	__	____	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: _____ Relationship to client: _____
Signature

Date: _____