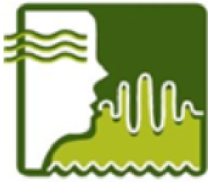

The Speech, Voice & Language Clinic

www.speechvoice.ca

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Parent Questionnaire

Child's Name: ____

Date of birth: Day: ______ Month: _____ Year: _____

Please calculate your child's chronological age: (i.e. 2 yrs, 6 mo) Years ___ Months___

Address: Street ______________________ City:____________________________

Postal code: ________________________ Home phone: _____________________

Cell phone: ___________________ Mothers work phone: _____________________

Father work phone: ___________________ Email: ___________________________

Preferred number to be reached: _______________________________________

Mother name: _____________________ Father name: _______________________

Mother occupation: _________________ Father occupation: ___________________

Referring physician: _________________ Child's physician: ___________________

Dr.'s address (where report is to be sent) Street: ________________ Suite: _________

City: _____________ Postal code: ________

Phone: ____________ Fax: _____________

Reason for referral (please check all that apply)

Speech ____ Language ____ Voice ____ Resonance ____ Stuttering ____

Social skills ____ Learning ____ Reading _____ Spelling _____

Other ____ (please describe in detail) _________________________________

____

____

Description of Problem:

1. Describe your child's speech problem/communication challenge and your concern about your child today: ______________________________
____
____
____
____
2. When was it first noticed? ______________________________
By whom? ______________________________
3. What do you feel has caused the problem?
____
____
____
4. Have you or any other family member attempted to correct the problem?
Yes **No**
If so, how?
____
____
____
How does your child react to these attempts? ______________________________
____
____
5. Is your child aware of his/her speech problem? **Yes** **No**
If yes, what is his/her reaction to the problem? ______________________________
____
____
6. How does the family react to the problem? ______________________________
____
____
7. Has anyone else in your family had speech/language/learning problems? (please describe in detail)
____
____
____
____

8. Does your child have difficulties in other areas? If so, please describe them?

____

____

9. Have you had any other previous interventions? (i.e. previous evaluation, previous therapy, tutoring, etc.) ____

____

____

10. What percentage of the time is your child understood by:

    Mom ____________________________

    Dad _____________________________

    Younger siblings ___________________

    Older siblings _____________________

    Other children _____________________

    Extended family ____________________

    Unfamiliar adults ___________________

11. Describe what it is like to have a conversation with your child:

____

____

Instructions regarding historical information: If you do not remember, write D. R.

If you do not remember but you recall the development was normal, write N.

Birth and Pregnancy History:

1. Was the pregnancy normal? **Yes** **No**

   If no, please describe the complications. _________________________________

   ____

   ____

2. What was the duration of the pregnancy? _________________________________

3. Was the birth normal? **Yes** **No**

   If no, please describe the complications. _________________________________

   ____

   ____

4. Were any medications given during pregnancy or birth?____________________
____
____

5. Were any of the following present at or shortly after birth:
   Anoxia (lack of oxygen) **Yes** **No**
   Jaundice (yellowish discolouration) **Yes** **No**
   Cyanosis (bluish discolouration) **Yes** **No**
   Rh incompatibility **Yes** **No**
   Other____________________________
   APGAR score: ____________________

Developmental History:

Please indicate at which age your child did each of the following:

Crawled ____
Stood alone ____
Walked ____
Swallowed ____
Chewed ____
Slept ____
Conflict/protest ____
Separation ____
Fed him/herself ____
Dressed him/herself ____
Was toilet trained during the day ________________________________
Toilet trained day and night _____________________________________

Speech History:

Please indicate at which age your child did each of the following:

Cooing ____
Babbling ____
Said his/her first words ____
Combine two words ____

Spoke in sentences ____

Cried ____

Laughed ____

Smiled ____

Gestured ____

Got frustrated ____

Oral Motor History:

1. Was your child breastfed? **Yes** **No** How long? ______________________
2. Was your child bottle fed? **Yes** **No** How long? ______________________
3. Describe the following oral motor behaviour/characteristic in your child?

   Latching on ____

   Sucking ____

   Swallowing ____

   Transition from bottle to cup ______________________________________

   Eating pablum/baby food ____

   Eating solids (i.e. meat, vegetables) _________________________________

   Managing food in oral cavity _______________________________________

   Messiness/neatness around eating ___________________________________

   Food pocketing (in cheeks) ____

   Food preferences ____

   Food aversions ____

   Food allergies ____

   Managing saliva ____

   Drooling ____

   Night (nocturnal) drooling ____

4. Has your child had any digital or sucking habits? If YES, at what age?
   a. Thumb sucking **Yes** **No** _________________________________
   b. Finger sucking **Yes** **No** _________________________________
   c. Soother **Yes** **No** ______________________________________
   d. Sucking on a blanket **Yes** **No** ____________________________

e. Sucking on a toy **Yes** **No** ________________________________

f. Sucking on hair **Yes** **No** ________________________________

<u>Linguistic History:</u>

1. What languages does your child speak or been exposed to? _______________

   ____

2. If more than one language; who taught these languages? **Mother** **Father** **Grandparents** **Babysitter** (please circle and elaborate)

   ____

3. Is one language more dominant than the other? (please describe)

   ____

<u>Medical History:</u>

1. Has your child even experienced any of the following?

   At what age Resolved/Ongoing Treatment given

   Ear infections ____

   Allergies ____

   Tonsillitis ____

   Frequent colds ____

   Hearing loss ____

   Operations ____

   Accidents ____

2. Please describe any other medical conditions: _________________________

   ____

   ____

   ____

<u>Other Services:</u>

1. Has your child previously seen any of the following professionals? If so, please indicate dates, places and names if possible.

   Speech pathologist ____

   Audiologist ____

   ENT physician ____

Psychologist ____
Physiotherapist ____
Neurologist ____
Psychiatrist ____
Developmental pediatrician ____________________________________
Developmental specialist (please describe) ______________________
Behavioural therapist (what were the goals?) ____________________
Dentist ____
Orthodontist ____
Chiropractor ____
Naturopath ____
Respirologist ____
Bariatric clinic services _______________________________________
Nutritionist (any diet modification) _____________________________
Other services ____

Academic History:

2. School/Preschool: ____
3. School Board: ____
4. Grade/Level: _______ 4. Language of Instruction/Program/Stream: ____________

5. If your child's teacher concerned about your child's development? **Yes** **No**

___speech development ___following directions ___expressing him/herself
___reading ___spelling ___homework completion ___making friends ___bullying
___academic achievement ___any other difficulties your child may be experiencing

Please explain: ____
____
____
____

6. Have any of the following tests been done at school? Please give the date if applicable.
Hearing test ____

Speech or language testing ____
Psychological testing ____
Other ____

Social history:

1. Who are the family members living in the same home as your child?

   Name **Age** **Occupation/Grade**

   ____
   ____
   ____
   ____
   ____

2. Does your child play regularly with friends his/her own age?

   ____
   ____

3. Apart from contact at school, how often does your child play with other children?

   ____
   ____
   ____

4. Please describe any special interests, play interests, activities, sports or hobbies your child enjoys.

   ____
   ____
   ____
   ____

5. Does your child have any unusual habits/behaviours/preferences that are either interesting/puzzling or concerning? (please describe)

   ____
   ____
   ____
   ____

6. Is there anything else we should know about your child, his/her family or you, that would better help us understand him, in order to serve you, your family and your child better?

____
____
____
____

7. Please let us know your goals and expectations:

____
____
____
____

Thank you for your time and patience filling out this questionnaire.

Parent/informant (please print): ____

Client Signature: _________________________________ Date: ________________

Clinician Signature: ______________________________ Date: ________________