

Developmental Therapy Associates & Absolute Speech and Language Therapy

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SPEECH QUESTIONNAIRE

Child's nam	e: Last name	First name		
Child's date	of birth:			
Questionna	ire completed by:			
Relationship	to Child:			
Has your child ever had a speech evaluation: Yes No				
If y	es, where:			
If y	es, when:			
Has your child ever had speech therapy: Yes No				
If y	res, where:			
If y	res, when:			
Has your child ever had other therapy (occupational therapy, physical therapy, etc: Yes No				
If y	es, what type of therapy:			
W	nere:			
W	hen:			
Ifa	applicable, is your child still receiving therapy:	Yes No		

Any additional information you would like to relay:

Family History

Family history of speech delay/disorder: Yes No

If yes, who in the family had/has a speech delay/disorder:

If yes, what type of speech delay/disorder:

If yes, did family member receive speech therapy: Yes No

Any additional comments:

Is your child currently diagnosed with or is there any family history of the following disorder/diagnosis (if yes, please list child or family member(s)

Disorder			Family Memeber
Apraxia	Yes	No	
Fluency	Yes	No	
Articulation delay	Yes	No	
Autism	Yes	No	
Auditory processing	Yes	No	
Cleft palate	Yes	No	
ADD/ADHD	Yes	No	
Seizures	Yes	No	
Hearing impairment/ frequent ear infections	Yes	No	

Are there other languages than English spoken at home: Yes N_0

If yes, please list language(s):

Has your child ever had their adenoids/tonsils removed: Yes No

If yes, please explain:

Hearing History:

Did your child pass their newborn hearing screening: Yes No

If no, please explain:

Does your child have a history of ear infections: Yes No

If yes how many:

Age of first occurrence: When was last occurrence:

Has your child ever had pressure equalizing (PE) tubes inserted: Yes No

If yes, when were they inserted:

In both ears: Yes No

Currently still in place: Yes No

Has your child's hearing ever been screened or tested: Yes No

If yes, when was it last tested:

Results of testing: PASS FAIL

Any hearing concerns/issues at this time: Yes No

If yes, please explain:

Speech and Language History

Is your child verbal: Yes No

How does your child most frequently communicate:

Gestures/Pointing/Grunting Yes No

Using single words Yes No

Using 2-3 word phrases Yes No

Using sentences Yes No

Other

Can your child speak in conversation: Yes No

Does your child have difficulty producing sounds: Yes No If yes, which sounds do you notice them having difficult with: Is your child easily understood by family members: Yes No Is your child easily understood by others: Yes No Does your child ever get frustrated when they are not understood: Yes No If yes, please provide more details: Does your child stutter: Yes No If yes, please provide more details: Does your child follow simple directions: Yes No Does your child follow multiple-step directions: Yes No Does your child have any behavioral difficulties that we should be aware of: Yes No If yes, please provide more details: What are your current concerns regarding your child's communication: How old was your child when you started becoming concerned with their communication skills: What are your child's current interests/favorite toys: Additional pertinent information that you would like to share: