

Therapist: _____
Evaluation Date: _____



**PARENT QUESTIONNAIRE
SPEECH AND LANGUAGE THERAPY**

Welcome to Children's Developmental & Rehab Services. The information you provide on this form will help us prepare for your child's upcoming speech-language evaluation. Please print and complete the form then fax or mail it to the clinic where your child's evaluation will be completed (contact information is on the last page).

Today's Date: _____

Child's Name: _____

Date of Birth: _____

Medical or Developmental Diagnoses: _____

School Diagnoses: _____

Language(s) Spoken at Home: _____

Caregiver's Name: _____ Relationship to Patient: _____

Caregiver's Name: _____ Relationship to Patient: _____

Brothers/Sisters:

Name: _____ Age: _____ Grade: _____

Name: _____ Age: _____ Grade: _____

Name: _____ Age: _____ Grade: _____

Who currently lives in the home? (including foster children and those living part time with family):

Who is your child's primary caregiver? _____

REASON FOR REFERRAL

Who referred you to Children's? _____

What are your main concerns about your child's speech and language skills?

When did you first become concerned with your child's speech and language skills?

What would you like your child to be doing 6 months from now?

SPEECH AND LANGUAGE DEVELOPMENT

How often does your child use the following ways to communicate?

1 word	Never <input type="checkbox"/>	Rarely <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Frequently <input type="checkbox"/>
2 word phrases	Never <input type="checkbox"/>	Rarely <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Frequently <input type="checkbox"/>
3 or more word sentences	Never <input type="checkbox"/>	Rarely <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Frequently <input type="checkbox"/>
Gestures	Never <input type="checkbox"/>	Rarely <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Frequently <input type="checkbox"/>
Signs	Never <input type="checkbox"/>	Rarely <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Frequently <input type="checkbox"/>
Communication Device	Never <input type="checkbox"/>	Rarely <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Frequently <input type="checkbox"/>

Does your child have a communication device? Yes No

If yes, what type of device does your child use? _____

Does your child respond to his/her name? Yes No

Does your child try to get you to notice interesting objects? Yes No

When you point to a toy across the room, does your child look at it? Yes No

Does your child engage in pretend play with toys (ex. feed a doll) Yes No

Does your child play well with other children? Yes No

If yes, what ages? _____

Do you have concerns about your child stuttering? Yes No

If yes, when did the stuttering begin? _____

Has anything helped decrease your child's stuttering? _____

Does your child seem to be aware of the stuttering? Yes No

Do you have concerns about your child's voice (i.e. soft, hoarse, loud)? Yes No

THERAPY

Has your child's speech-language development been evaluated before: Yes No

If yes, when: _____ where (school, clinic, etc): _____

Results: _____

Is your child currently receiving:

Speech Therapy: Yes No

If yes, how often: _____ where: _____

Occupational Therapy: Yes No

If yes, how often: _____ where: _____

Physical Therapy: Yes No

If yes, how often: _____ where: _____

Additional comments: _____

EDUCATION

Does your child attend daycare? Yes No

If yes, how often: _____ where: _____

Where does your child go to school? _____

School District: _____

Grade: _____

Does your child have an IFSP, IEP or 504 plan? Yes No

MEDICAL HISTORY

Were there any problems during your pregnancy? Yes No

Were there any problems during your child's birth? Yes No

Has your child had any significant illnesses, injuries, and/or hospitalizations?
Yes No

If yes to any of the above, please describe: _____

List any medications currently being taken: _____

Does your child have any allergies (medicine, food, environment)? Yes No

If yes, please list: _____

Has your child been evaluated by an ear, nose and throat (ENT) doctor? Yes No

If yes, why: _____

Does your child have a history of frequent ear infections? Yes No

If yes, please describe: _____

Does your child have ear (PE) tubes? Yes No

Has your child's hearing been tested? Yes No

If yes, when: _____ where (school, clinic, etc): _____

Results: _____

Has your child been seen by a psychologist? Yes No

If yes, when: _____ where (school, clinic, etc): _____

Results: _____

Does your child have behaviors that:

Impact learning/school	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Interfere with social interactions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are aggressive towards self	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are aggressive towards other people	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are aggressive towards objects/property	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If yes to any of the above, please explain: _____

Does your child have a behavior plan? Yes No

If yes, please explain: _____

FEEDING DEVELOPMENT

Is your child's weight gain a concern? Yes No

If yes, please explain: _____

Does or did your child have difficulty starting to eat solid foods? Yes No

Does or did your child have difficulty swallowing? Yes No

Does your child allow his/her teeth to be brushed? Yes No

Will your child allow you to touch his/her mouth on the inside? Yes No

FAMILY HISTORY

Does your child have family members with any of the following concerns:

Speech or Language Yes No If yes, who? _____

Stuttering Yes No If yes, who? _____

Hearing Loss Yes No If yes, who? _____

Cleft Palate Yes No If yes, who? _____

Autism Spectrum Yes No If yes, who? _____

Developmental Delay Yes No If yes, who? _____

Reading or Learning Disability Yes No If yes, who? _____

ADHD Yes No If yes, who? _____

Additional comments or concerns: _____

Please return this form as soon as possible to:

Minneapolis 2530 Chicago Avenue South, Suite 267, Minneapolis, Minnesota 55404

Phone: (612) 813-6709 Fax: (612) 813-6593

St. Paul 345 North Smith Avenue, St. Paul, Minnesota 55102

Phone: (651) 220-6880 Fax: (651) 220-7299

Minnetonka 5950 Clearwater Drive, Suite 500, Minnetonka, Minnesota 55343

Phone: (952) 930-8630 Fax: (952) 930-8640

Twin Lakes 1835 West County Road C, Suite 130, Roseville, Minnesota 55113

Phone: (651) 638-1670 Fax: (651) 638-1675

Woodwinds 1825 Woodwinds Drive, Suite 100, Woodbury, Minnesota 55125

Phone: (651) 232-6860 Fax: (651) 232-6766

Maple Grove 7767 Elm Creek Boulevard, Suite 300, Maple Grove, Minnesota 55369

Phone: (763) 416-8700 Fax: (763) 416-8701

Thank you. We look forward to meeting you and your child.