PARENT QUESTIONNAIRE
SPEECH AND LANGUAGE SERVICES
CHILDREN'S HOSPITALS AND CLINICS OF MINNESOTA

Please return as soon as possible.
The information you give us will help us to understand your child and to better plan for his or her visit. Not all questions may apply to your child. Please print a copy and send or fax the completed form to the clinic where your child's evaluation is scheduled.

Date: _____

Child's Name: _____

Date of Birth: _____

Medical or Developmental Diagnosis: _____

Language(s) Spoken at Home: _____

Caregiver's Name: _____ Relationship to Patient: _____

Caregiver's Name: _____ Relationship to Patient: _____

Brothers/Sisters:

Name	Age/Sex	Grade

County/School District: _____

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?

_____

_____

_____

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: _____

_____

Has your child had a problem with ear infections? Yes ☐ No ☐ Age Started: _____

If yes, how many infections did he/she have in the past year? _____

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

Has your child's hearing been tested? Yes ☐ No ☐

If yes, when/where: _____ Results: _____

Does your child have any food allergies? Yes ☐ No ☐

If yes, please list: _____

FEEDING DEVELOPMENT

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 for his/her teeth to be brushed? Yes ☐ No ☐

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

Do you or your child's Dr. have any concerns about weight gain? Yes ☐ No ☐

SPEECH AND LANGUAGE DEVELOPMENT

Does your child use:

Speech? Yes ☐ No ☐

Gestures? Yes ☐ No ☐

A combination of speech and gestures? Yes ☐ No ☐

Signs or other communication devices? Yes ☐ No ☐

Give three examples of things your child says:

1. _____

2. _____

3. _____

RESONANCE/VOICE/STUTTERING

Please answer the following questions **ONLY** if you have concerns regarding these problems:

RESONANCE/VOICE:

Does your child sound like he/she always has a cold? Yes ☐ No ☐

Has your child been evaluated by an Ear, Nose and Throat doctor? Yes ☐ No ☐

If yes, Doctor's name: _____

Results: _____

Do you have concerns regarding your child's voice quality? Yes ☐ No ☐
(e.g., soft, hoarse, breathy, strained, loud)

STUTTERING/FLUENCY:

Describe your child's pattern of stuttering: _____

When did the stuttering begin? _____

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

Has anything helped to decrease your child's stuttering? _____

_____

BEHAVIOR

What does your child do when upset or angry? _____

_____

Does your child play with other children? Yes ☐ No ☐

If so, what are their ages? _____

In what settings (home, school, daycare, friend's homes)? _____

_____

EDUCATIONAL INFORMATION

Does your child currently attend school or get help from the public school system? Yes ☐ No ☐

Current School/Program: _____ Dates of Attendance: _____

THERAPY

Is your child currently receiving:

Occupational Therapy: Yes ☐ No ☐

Physical Therapy: Yes ☐ No ☐

Speech Therapy: Yes ☐ No ☐

If yes to any of the above, who are they working with and where: _____

_____

_____

FAMILY HISTORY

Does your child have family members with any of the following problems? Please give the person's relationship to the child and the nature of the problem:

Problem:			**Person's Relationship/Problem:**
Speech or language	Yes	No	
Stuttering	Yes	No	
Hearing	Yes	No	
Vision	Yes	No	
Cerebral Palsy	Yes	No	
Other birth defect (e.g. cleft palate)	Yes	No	
Reading or learning disability	Yes	No	
Slow Development or Cognitive Impairments	Yes	No	
Other: (please describe below)	Yes	No	

Please return this questionnaire before your appointment to help us plan a thorough evaluation. It may be returned in person, by mail, or by fax to:

Minneapolis 2530 Chicago Avenue South, Suite 267, Minneapolis, Minnesota 55404
Phone: (612) 813-6709 **Fax: (612) 813-6593**
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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
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