11030-101 Raven Ridge Road, Raleigh, NC 27614 Phone: 919-844-6611

Speech/Language Evaluation Intake Questionnaire

Child's Name _____ Date of Birth _____ Age_____ Gender M / F

Pediatrician/Group: _____

Name of person completing form_____ Relationship to child _____

How did you hear about us? _____

Does your child have any diagnoses? _____

Primary concern _____

When did you first notice this concern?_____

What, if any, action has been taken to address the concern? _____

What are your goals for this evaluation? _____

Prenatal/Birth History:

Were there any complications during pregnancy? Yes / No If yes, explain._____

Was your child born full term? Yes / No If no, how many weeks gestation? _____

Was your child in the NICU? Yes / No If yes, why and for how long? _____

List any surgeries that were required. _____

General Medical History:

Has your child ever been hospitalized? _____; If yes, why? _____

_____

Please list any medications your child is currently taking and the dosage per day: _____

_____

Has your child had any problems with his/her tonsils or adenoids? ____ If yes, please explain: _____

_____

Does your child: Drool Yes / No Have an open mouth posture Yes / No ?

Is there a history of high fevers or seizures? Yes_____ No_____

Does your child have a history of ear infections? Yes_____ No____ If yes, when and how were they treated?

_____

Is your child visually impaired? Yes / No Is your child hearing impaired? Yes / No

When was your child's last hearing assessment? _____ What were the results? Pass_____ Fail_____

Developmental History:

When did your child sleep through the night_____ roll over _____ sit independently _____

crawl _____ walk _____ say first words_____ toilet train _____?

Is/has your child required any other therapy? _____ If yes, explain. _____

_____

Do you have any other developmental concerns? Yes / No If yes, what? _____

Does your child attend day care or school? Yes / No If yes, where?_____

Does your child make eye contact? Yes / No

Sensory Processing History:

Does your child like to swing? Yes / No Does your child play in/with: sand / grass / PlayDoh ?

Is your child sensitive to: fabrics / tags in clothing / loud sounds / messiness ?

Allergies and Food Intolerances:

Does your child have a diagnosis of food, medication, or environmental allergies? Yes ____ No ____

Has your child ever had allergy testing? Yes ____ No ____; If yes, type of test and results: _____

_____

If no, do you suspect any allergies? Yes ____ No ____; If yes, please list: _____

Does anyone in your family have allergies or food intolerances? Yes ____ No ____; If yes, please list relationship to child and what they are allergic to: _____

Is your child allergic to latex? Yes / No

Feeding History:

Do you have any concerns regarding issues related to feeding or swallowing? Yes_____ No_____

How is your child currently fed? Breast___; Bottle___; NG Tube___; G-Tube___; Puree___; Solids ___

Other_____

Does your child currently drink from a bottle____; sippy cup____; cup with straw____; open cup____?

Does your child choke____; cough____; gag____; vomit during feeding____?

Oral Motor History:

How many teeth does your child have?_____ Is tooth brushing stressful? Yes ____ No ____

Has your child ever had any major dental work completed? Yes_____ No_____

Did your child mouth objects as an infant? Yes ____ No ____ Does your child mouth objects? Yes ____ No ____

Does your child take a pacifier? Yes ____ No ____, if no did she/he?_____

Does your child suck her/his thumb? Yes ____ No ____if no did she/he?_____

Speech/Language History:

Does your child speak any other languages? Yes_____ No_____

Has your child received speech/language services in the past? Yes_____ No_____ If so, when and for how long?

_____

Do you have any other children? Yes_____ No_____ If so, what are their names and ages?

_____

Does your child have opportunities to interact with children outside of the household? Yes_____ No_____

Is there any family history of speech and/or language delays? Yes_____ No_____

If so, please describe relationship to child, treatment implemented, and duration of services:

_____

Do you have any concerns regarding: Stuttering—Yes____ No____, Voice Quality—Yes____ No____,

Volume—Yes____ No____?

When did your child say his/her first word? _____ What was your child's first word? _____

Approximately how many words does your child currently use? _____ Examples: _____

Does your child use 2+ words together? Yes____ No____ Examples: _____

Does your child seem to understand you? Yes_____ No_____ Others? Yes_____ No_____

On a scale of 1-10 (1: not at all, 10: 100% of the time): How well do you understand your child? _____

How well do others understand your child? _____

Does your child look at the speaker's face? Yes_____ No_____

What sounds does your child use? (Circle all that apply) P M H N W B K G D T S Z F V

What is your child's main form of communication? Words____; Gestures ____; Signs ____; Body Language ____;

Grunting ____; Vocalizing ____; Other: _____

How does your child express his/her wants and needs? _____

Does your child follow simple commands? Yes____ No____ 2-step commands? Yes____ No____

Does your child ask questions? Yes____ No____ Does your child imitate new words? Yes____ No____