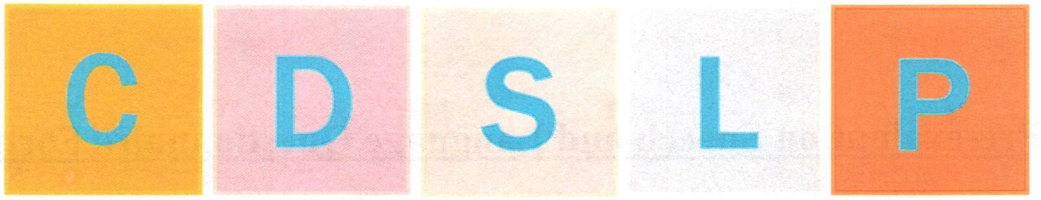

Central Delaware Speech Language Pathology, Inc.

Specializing in the Diagnosis and Treatment of Speech-Language Disorders
ASHA Certified, Licensed in Delaware

Child's Name:_____ **Date:**_____

Pre-evaluation Speech and Language

Have any other doctors/specialists seen your child (audiologists, psychologists, occupational therapists, special educators, etc.)? If yes, please indicate the type of specialist, when the child was seen, and the specialist's conclusion or suggestions.

Name of Doctor/Specialist	Date(s) of Evaluation/Treatment	Please explain conclusions/treatment applicable

Pre-evaluation Speech and Language Questionnaire Form

Developmental History:

Please provide the approximate age at which your child began to do the following activities:

Sit	
Crawl	
Stand	
Walk	
Feed Self	
Dress Self	
Use Toilet	

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Pre-evaluation Speech and Language Questionnaire Form

Speech and Language Development:

Please provide the approximate age at which your child began to do the following (please indicate if your child has not yet met these speech and language milestones):

Use single words (e.g., mommy, no, doggie)	
Combine words (e.g., me go, mommy car, etc.)	
Name simple objects (e.g., dog, car, tree, etc.)	
Use simple questions (e.g., where's doggie, etc.)	
Engage in conversation	

Describe your child's Speech-Language difficulties: _____

_____

_____

Is your child aware of his/her difficulties? If yes, how does he/she feel about them? _____

_____

How does your child usually communicate (e.g., gestures, sign language, single words, phrases, sentences)?

_____

_____

Is it difficult for you or others to understand your child's speech? _____

_____

Are there any specific sounds that you feel your child makes incorrectly? _____

_____

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Pre-evaluation Speech and Language Questionnaire Form

Speech and Language Development:

Does your child seem to have difficulty understanding and following directions?_____

_____

Does your child respond consistently to his/her name? _____

_____

Describe your child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, etc): _____

_____

_____

Do you suspect any problems with hearing? _____

_____

Has your child's hearing ever been tested? If yes, **when and what were the outcomes of the test?**_____

_____

_____

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Pre-evaluation Speech and Language Questionnaire Form

General/Social Development:

Does your child:

_____Sleep well

_____Eat well

_____Interact well with family members

_____ Interact/play well with peers

_____Play well by self

Behavioral Characteristics (please check all that apply):

_____Cooperative

_____Attentive

_____Willing to try new activities

_____Plays alone for reasonable amounts of time

_____Separation difficulties

_____Easily frustrated

_____Stubborn

_____Restless

_____Poor eye contact

_____Easily distracted/short attention span

_____Destructive/aggressive

_____Withdrawn

_____Inappropriate behavior

_____ Self-abusive behavior

Oral Motor and Feeding:

Does your child (please check all that apply):

_____ Avoid foods with certain textures (e.g., crunchy, chewy, soft, etc.)

_____ Avoid foods *of* certain temperatures (e.g., cold, hot, warm)

_____ Avoid certain food tastes (e.g., sweet, salty, spicy, sour, etc.)

_____ Only eat specific brands of food

_____ Gag/cough on food

_____ Have a history of choking incidents

_____ Frequently cry during meals

_____ Have poor weight gain

_____ Have gastrointestinal issues

_____ Have an open mouth posture or drooling?

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Pre-evaluation Speech and Language Questionnaire Form

_____ Currently put toys/objects in his/her mouth

_____ Refuse to allow his/her teeth to be brushed

Are there or have there been any other feeding concerns (e.g., problems with sucking, swallowing, drooling, chewing, etc.)?_____

_____

_____

Sensory/Motor Development:

Is your child particularly sensitive to touch? If yes, please explain. _____

_____

_____

Does your child especially enjoy fast movement and activities involving motion?

_____

_____

Do you feel your child has established hand dominance? If yes, please state if right or left handed. _____

_____

Does your child have difficulty with fine motor tasks (e.g., legos/blocks, stringing beads, cutting, coloring)? _____

_____

_____

Does your child have difficulty walking, running or participating in other activities which requires small or large muscle coordination? _____

_____

_____

Is your child able to participate in his/her self care (e.g., feeding, toileting, etc.) _____

_____

_____

Do you allow edibles (food, drink) as a means of reinforcing your child?

_____Yes _____No

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Pre-evaluation Speech and Language Questionnaire Form

Child's Name:_____ **Date:**_____

Family History:

Mother's Name: _____ Cell Phone: _____

Mother's Occupation: _____ Business Phone: _____

Father's Name: _____ Cell Phone: _____

Father's Occupation: _____ Business Phone: _____

Brothers and Sisters (names and ages): _____

_____

Does the child live with both parents? _____

If no, with whom does the child live? _____

If adopted, what age? _____

What are your goals for your child?

_____

_____

_____

What really motivates your child? (toys, Elmo, music, puzzles, etc.) _____

_____

If previous therapy has been slow/unsuccessful, why do you think it is so?

_____

_____

_____

How do you handle difficult behaviors (if any) at home?

_____

_____

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Do you think your child's speech/language is holding him/her back? Please explain._____

_____

_____

_____

Please explain any techniques that work really well for your child (earning stickers, free time, play…)_____

_____

_____

Prenatal and Birth History:

Describe mother's general health during pregnancy (illnesses, accidents, medication requirements, etc.).

Length of pregnancy: _____ Child's birth weight: _____

Describe delivery (any complications): _____ _____ _____

_____ _____ _____ _____ _____

Describe child's general health at birth: _____ _____

_____

Child's length of stay in hospital _____

Child's general health is: (circle one) Good Fair Poor

Please provide approximate ages at which your child has experienced any of the following illnesses/conditions:

Adenoidectomy_____ Headaches_____ Pneumonia_____

Asthma_____ Head Injury_____ Seizures_____

Allergies_____ Hearing Loss_____ Sinusitis_____

Chicken Pox_____ Heart Problems_____ Sleep Difficulty_____

(Frequent) colds_____ High Fevers_____ Thumb/Finger Sucking____

Croup_____ Influenza_____ Tonsillectomy_____

Ear Infections_____ Measles_____ Vision Problems_____

How Often?_____

Ear Tubes_____ Meningitis_____ Other_____

When?_____

Epilepsy_____ Mumps_____

Prenatal and Birth History:

Describe any major accidents, surgeries, illnesses, or hospitalizations your child has had:

_____

_____

Is your child currently under a physician's care? If yes, why? _____

_____ _____ _____ _____

Please list any medications your child is currently taking: _____

_____

Has your child had any negative reactions to medication? Please describe: _____

Are your child's immunizations up to date? _____

Is your child sensitive to latex? _____

Has your child had speech and language therapy in the past? If yes, where, when, and for how long? _____

Educational History:

Current grade? _____

What school does your child attend? _____

Current teacher's name? _____

Has your child ever repeated or skipped a grade? _____

Is your child experiencing any learning or social problems in school? If yes, please explain.

_____

_____

What are your child's strengths and/or best subjects?

_____

_____

Is your child having difficulty with any subjects?

_____

_____

Does your child receive special services within the school environment? If yes, has an Individualized Education Plan (IEP) been developed? If yes, please describe implemented goals._____

_____