Central Delaware Speech Language Pathology, Inc.

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

Speech and Language Reassessment Questionnaire

Please complete all applicable questions in full detail. If you have any questions, please ask!

Today's date: _____Child's Name_____Date of Birth_____Gender____

Address: _____ Home Phone:_____

Mother's Name: _____ Cell Phone:_____

Father's Name: _____Cell Phone:_____

Email Address:_____

Does the child live with both parents? ____ If no, with whom does the child reside? _____

Primary Care Physician: _____

Insurance Information

Primary Insurance _____ Policy ID # _____ Group # _____
Policy Holder _____ Relation to Patient _____

Secondary _____ Policy ID # _____ Group # _____
Policy Holder _____ Relation to Patient _____

Describe your child's current speech-language/communication difficulties:

- ☐ Stuttering/Fluency
- ☐ Reading
- ☐ Voice
- ☐ Social Skills
- ☐ Functional Communication
- ☐ Language
- ☐ Verbal Expression
- ☐ Other: _____
- ☐ Listening Comprehension
- ☐ Vocabulary
- ☐ Speech (Articulation)

Please describe the marked concerns below:

What are your goals in securing therapy for your child?

How do you feel your child has been progressing?

Is there anything we should know about your child/family that might have an effect on their progress in speech therapy?

Are there any health concerns for your child?

What is your child's current educational placement? Is there an IEP in place?

Please list any other doctors/specialists who have seen your child (audiologists, psychologists, occupational therapists, special educators, etc.). 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 Treatment/Evaluation	Please explain conclusions/ treatments if applicable

Medications

Please list any **current** medications your child is currently taking:

Allergies

Please list any **current** allergies that your child has.

CDSLP Survey

Please take a moment to complete the survey. Your opinion is important to us and will help the CDSLP staff make informed decisions about the needs of our clients and families.

Front Office: Do you find the front office staff to be helpful and courteous?
(please circle one)

Always Sometimes Never

Do you find the Waiting area comfortable and clean, and our restrooms to be clean and stocked?
(please circle one)

Always Sometimes Never

Comments:_____

Please share your experience with your child's Therapist.

Therapist Name: _____

1. Do you feel your child's Therapist takes time to build a positive relationship with your child?
(please circle one)

Yes Somewhat No

Comments:_____

2. Does your child's Therapist provide continued feedback and suggestions regarding your child's progress?
(please circle one)

Yes Somewhat No

Comments:_____

Is there anything you feel needs to be addressed for your child's overall experience while attending Sessions?_____

_____

Overall Experience

1. Would you be interested in participating in additional programming such as social skills groups, parent workshops, other?

_____

2. How has CDSLP made a difference in the life of your child, or your family?

_____

_____

May we **anonymously** share your feedback, including on social media? All identifying information will be excluded. (please circle one)

Yes No

_____ _____

Signature Date

Thank you for your feedback.
Please write any further comments on the reverse side.

541 S. Red Haven Lane, Dover, DE 19901 (Phone) 302-674-3350 (Fax) 928-752-3350