Atlantic Speech Therapy
1430 Commonwealth Dr., Suite 300
Wilmington, NC 28403
PHONE: 910.343.5885 | 910.679.8075 **FAX:** 815.550.1949 | 910.343.5886

SPEECH AND LANGUAGE HISTORY QUESTIONNAIRE

Identifying and Family Information

Child's Name: _____ Birthdate: _____ Age: _____ Sex: ☐ M ☐ F

Mother's Name: _____ Daytime Phone: _____ Cell: _____

Father's Name: _____ Daytime Phone: _____ Cell: _____

Child lives with (check one):

☐ Birth Parents ☐ Foster Parents ☐ One Parent

☐ Adoptive Parents ☐ Parent and Step-Parent ☐ Other _____

Other Children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one? _____

Does the child speak the language? ☐ Yes ☐ No

Does the child understand the Language? ☐ Yes ☐ No

Who speaks the language? _____

Which language does the child prefer to speak at home? _____

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Birth History

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

Birth weight: _____ Hospital Duration: _____

Were there any problems during pregnancy/delivery? _____

_____

How many months was the pregnancy? _____

Did the child go home with his/her mother from the hospital? ☐ Yes ☐ No

If child stayed in the hospital, please describe why and how long. _____

_____

Medical History

If checked, please provide the approximate age at which child suffered the following illnesses and conditions:

☐ Adenoidectomy:	☐ Allergies:	☐ Asthma:
☐ Breathing difficulties	☐ Chicken Pox:	☐ Colds:
☐ Convulsions:	☐ Croup:	☐ Dizziness:
☐ Draining Ear:	☐ Ear Infections: How Often:	☐ Ear Tubes
☐ Encephalitis:	☐ Flu:	☐ Headaches:
☐ Head Injury:	☐ High Fever:	☐ Influenza:
☐ Mastoiditis:	☐ Measles:	☐ Meningitis:
☐ Mumps:	☐ Scarlett Fever:	☐ Seizures:
☐ Sinusitis:	☐ Sleeping Difficulties:	☐ Thumb/finger sucking habit:
☐ Tonsillectomy:	☐ Tonsillitis:	☐ Vision Problems:
☐ ADD/ADHD		

Other Serious injury/surgery: ☐ Yes ☐ N

If yes, please explain: _____

_____

Has the child been diagnosed with any medical disorder? ☐ Yes ☐ No

If yes, please explain: _____

_____

Is your child currently (or recently) under a physician's care? ☐ Yes ☐ No

If yes, why? _____

Please list any medications your child takes regularly: _____

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Speech-Language-Hearing

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

Has he/she ever had a hearing screening/test? ☐ Yes ☐ No

If yes, results and date of screening _____

Has your child ever had speech therapy? ☐ Yes ☐ No

If yes, where and when? _____

If through school is there a current IEP, PSSP or 504 plan in place? ☐ Yes ☐ No

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? ☐ Yes ☐ No

If yes, where and when? _____

Is your child aware of, or frustrated by, any speech/language difficulties? _____

_____

What do you see as your child's most difficult problem in the home? _____

_____

What do you see as your child's most difficult problem in school? (If applicable) _____

_____

Developmental History

Please tell approximate age your child achieved the following developmental milestones:

_____ sat alone

_____ babbled

_____ put two words together

_____ walked

_____ grasped crayon/pencil

_____ said first words

_____ spoke in short sentences

_____ toilet trained

Does your child…

☐ choke on food or liquids?

☐ currently put toys/objects in his/her mouth?

☐ brush his/her teeth and/or allow brushing?

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Current Speech-Language-Hearing

Child's Name:_____ Date of Birth: _____

Does your child…

☐ repeat sounds, words or phrases over and over?

☐ understand what you are saying?

☐ retrieve/point to common objects upon request (ball, cup, shoe)?

☐ follow simple directions ("Shut the door" or "Get your shoes")?

☐ respond correctly to yes/no questions?

☐ respond correctly to who/what/where/when/why questions?

Your child currently communicates using…

☐ body language

☐ sounds (vowels, grunting).

☐ words (shoe, doggy, up).

☐ 2 to 4 word sentences.

☐ sentences longer than four words

☐ other _____

Behavioral Characteristics:

☐ cooperative

☐ attentive

☐ willing to try new activities

☐ separation difficulties

☐ easily frustrated/impulsive

☐ stubborn

☐ restless

☐ poor eye contact

☐ easily distracted/short attention

☐ withdrawn

☐ inappropriate behavior

☐ self-abusive behavior

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School History

Child's Name:_____ Date of Birth: _____

If your child is in school, please answer the following: (if applicable)

Name of school and grade in school: _____

Teacher's name: _____

Has your child repeated a grade? _____

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

_____

Is your child having difficulties with any subject? _____

_____

Is your child receiving help in any subjects? _____

_____

Additional Comments or Concerns

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____