



Advanced Therapy Care

Therapy Services for Children & Adults

New Patient Speech & Language Questionnaire

PATIENT INFORMATION			
Patient's Last Name:	First:	Initial:	Birthdate:
Current School:	Grade:	Services at School? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Are you concerned about your child's communication skills? Yes No

Please describe your concerns:

When did you become concerned about your child's communication?

Has your child received speech therapy before? Yes No

If yes, when and where?

Has your child had any significant health problems in his or her life? Yes No

If yes, please describe:

Does your child understand you?

- Some of the time
- Always
- Never

Compared to other children, my child....

- reacts differently to sound, light, or touch.
- struggles with school-related skills (writing, cutting).
- struggles with self-care skills (self-feeding, buttons).

Does your child have a history of any of the following? (If yes, please describe)

Chronic ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
P-E Tubes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hearing Loss/Deafness	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Thumb Sucking	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cleft Palate	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
ADD/ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tongue Clip	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hoarse Voice	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Developmental Delays	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Stuttering (Fluency)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Please select one statement that describes your situation the best.

- I can understand my child all of the time.
- I can understand my child most of the time (75%).
- I can understand my child some of the time (50%).
- I rarely understand my child (less than 50%).

Please select one statement that describes your child the best.

- My child uses less than 5 words.
- My child uses 5 to 25 words.
- My child uses 25 to 100 words.
- My child uses more than 100 words.

Please select the most appropriate statement to describe your child.

- My child uses single words. (e.g. "milk")
- My child combines two words. (e.g. "want milk")
- My child combines 3-4 words in sentences. ("I want milk, mom")
- I am not able to determine how many words my child is using.

Describe specific sound errors that you have noticed your child make. (e.g., my child can't say fish, he says pish)

Is there anything else that you would like to report in regards to your child and his or her speech production?
