Reingold Speech Therapy Services

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

PARENT QUESTIONNAIRE

The information you provide is very helpful in planning your child's plan of care. Please answer all questions as completely as possible. Please note "N/A" where necessary.

Child and Family Information:

Name of child: _____ Date: _____
Name by which your child is called: _____
Date of birth: _____ Age: _____ Gender: _____
Mother's Name: _____ Occupation: _____
Father's Name: _____ Occupation: _____
Address(es):_____
_____
Telephone # (Home): _____ (Work): _____ (Cell): _____
Email Address(es): _____
Referred by: _____ Telephone #: _____
Name of person completing this form: _____ Relationship: _____
Person to contact in case of emergency: _____ Telephone #: _____

Siblings:

Name:	Age:	Gender:	Grade:

Does anyone else in the family have speech, language, or hearing problems? ☐☐Yes ☐☐No

If yes, please describe:

_____
_____

What languages does your child speak? _____

Reingold Speech Therapy Services

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

Educational/ Social History

Please provide the name of your child's school and type of program he/she is currently enrolled along with the name of the classroom teacher.

Name of school Type of program Name of teacher

_____

_____

Has your child repeated a grade? ☐☐Yes ☐☐No If yes, what grade?

_____

Does your child receive assistance and/or special education services at school?

☐☐EIP ☐☐Tutoring ☐☐IEP ☐☐504 ☐☐Speech therapy ☐☐Occupational therapy ☐☐Physical therapy

How does your child interact with other children/siblings?

_____

_____

_____

What are your child's favorite activities, toys, and interests?

_____

_____

What things does your child do particularly well?

_____

_____

List your child's easiest and most difficult subjects/areas: _____

_____

What does your child have trouble doing? _____

Speech/Language History:

Has your child ever had a speech evaluation/screening? ☐☐Yes ☐☐No

Reingold Speech Therapy Services

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

If yes, where and when?_____

What were you told?

_____

_____

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

If yes, where and when? _____

What was he/she working on? _____

_____

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

If yes, please describe: _____

_____

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?

_____

How does your child communicate?

☐☐ Eye contact ☐☐Gestures ☐☐Vocalizations ☐☐Jargon ☐☐Sign language ☐☐PECS symbols ☐☐AAC device ☐☐Words ☐☐Phrases ☐☐Sentences ☐☐Conversation ☐☐Writing

What efforts does your child make to communicate his/her wants and needs when not understood?

_____

Is your child's speech understandable to you? ☐☐ to family? ☐☐ to friends? ☐☐ to strangers? ☐☐

Does your child's speech ever seem to stop or slow down for a period of time? ☐☐Yes ☐☐No

Reingold Speech Therapy Services

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

If yes, please describe:_____

Can your child follow directions? □□Yes □□No ___ 1 step ___ 2 step ___ Multi-step

How is your child's attention span?

_____

What have you done to help your child's speech and language? _____

_____

Birth / Medical History:

Is your child adopted? □□Yes □□No At what age? _____ From what country?_____

Please list any complications or illnesses that occurred during pregnancy (i.e. toxemia, CMV, etc.):

_____

_____

Were any medications taken during pregnancy? If yes, please list:

_____

Weight at birth _____ Was he/she full-term?)? □□Yes □□No

Please briefly describe your child's medical history including allergies:

_____

_____

Please list any medications your child takes regularly:

_____

_____

Has your child ever been examined by any other professionals (neurologist, OT, PT, etc.)? □□Yes □□No

If yes, please describe and provide a copy of the evaluation:

_____

What is and has been your child's general medical condition? _____

Please list any health conditions, surgeries, etc.: _____

_____

Reingold Speech Therapy Services

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

Has your child had his/her tonsils and adenoids removed? ☐☐Yes ☐☐No

Has your child had any ear trouble (earaches, infections)? ☐☐Yes ☐☐No How Many? _____

Has your child's hearing ever been tested? ☐☐Yes ☐☐No If yes, date of testing: _____

Results of Hearing Testing _____

Has your child ever had (PE) tubes inserted? ☐☐Yes ☐☐No

If yes, when? _____

Has your child ever worn glasses? ☐☐Yes ☐☐No

Does your child have dental problems? ☐☐Yes ☐☐No

Has your child had any seizures? ☐☐Yes ☐☐No If so, are these treated with medication? ☐☐Yes ☐☐No

_____

Does your child have any known skin allergies? ☐☐Yes ☐☐No To Latex? ☐☐Yes ☐☐No

Does your child have any food allergies or is he/she on a restricted diet? If so, please explain:

_____

Developmental History:

Were developmental milestones met on time? ☐☐Yes ☐☐No

If not, please describe: _____

Please give ages of development for the following behaviors:

Indicate the age at which your child: (Please write "NA" if not applicable)

Began to babble _____
Said first words _____
What were they? _____
Began asking questions _____
Sat up _____
Had a vocabulary of 50 words _____
Began to say two-word sentences_____
Began to say three-word sentences _____

Crawled _____
Walked _____

Does your child show aversive reaction to touching certain objects or textures? ☐☐Yes ☐☐No

___ on hands ___ on feet ___ on mouth/lips ___ on body ___ on face ___ inside mouth

Feeding:

Did your child have any feeding problems in early life? ☐☐Yes ☐☐No

If yes, please describe: _____

_____

Are there any present eating problems? ☐☐Yes ☐☐No

If yes, please describe: _____

_____

Does your child have difficulty chewing or swallowing? ☐☐Yes ☐☐No

Does your child drool? ☐☐Yes ☐☐No

Is your child a picky eater? ☐☐Yes ☐☐No

What are your child's favorite foods? _____

_____

Is there anything your child refuses to eat?

_____

Does your child use utensils? ☐☐Yes ☐☐No

How does your child take in liquid? ☐☐Syringe ☐☐Bottle ☐☐Nubby cup ☐☐Sippy cup ☐☐Straw ☐☐Cup

Reingold Speech Therapy Services

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

- Please provide any additional information that you think is important/relevant about your child's medical, social/emotional, and academic history:

_____
_____
_____
_____
_____
_____
_____
_