CHOOSE THE HOME TEAM CYPRESS CREEK THERAPY

Pediatric Speech Therapy Patient Questionnaire

GENERAL INFORMATION

Patient Name: _____Date of Birth_____Age:_____
Mother's Name_____ Father's Name_____
Does child live with both parents? ☐ Yes ☐ No
Referral Source_____Pediatrician/Family Dr._____
Brothers and Sisters (Include names & ages) _____
_____
Are there any speech, language or hearing impairments in your family? ☐ Yes ☐ No
If yes, please describe _____
_____
What languages are spoken at home/primary language ☐ English ☐ Other
If other, please provide other languages spoken_____

REASON FOR VISIT CHIEF COMPLAINT

Please briefly describe the reason for this visit:_____
_____
Describe the child's speech-language difficulties:_____
_____
When was the problem first noticed and by whom?_____
Has the problem changed since it was first noticed? How?_____
_____
How does the child usually communicate: ☐ Gestures ☐ Single Words ☐ Short Phrases
☐ Sentences ☐ Sign Language ☐ Augmentative Communication Device ☐ Other _____
Is the child aware of the problem? ☐ Yes ☐ No If Yes, how does he/she feel about it?
_____
Does your child demonstrate frustration when he/she is not understood? ☐ Yes ☐ No If Yes, please describe_____

Have any other speech-language specialists seen the child for an evaluation or treatment?
Whom and When _____
_____
Have any other specialists (Physicians, Special Education teachers, psychologists, etc.) seen the child? If yes, please list by whom and when? What were their conclusions or recommendations? _____
_____
_____
Please describe pregnancy history including any complications _____
_____
Please describe child's birth history (vaginal, caesarean, weeks born, complications, etc.)
_____

MEDICLAL HISOTRY

Has your child experienced any of the following? (please provide approximate age of onset)

☐ Allergies _____	☐ Encephalitis _____	☐ Mumps _____
☐ Asthma _____	☐ Epilepsy/Seizures _____	☐ Pneumonia _____
☐ Chicken Pox _____	☐ Feeding Tube_____	☐ PE Tubes _____
☐ Cleft Palate/Lip _____	☐ German Measles _____	☐ Reflux _____
☐ Colds _____	☐ Headaches _____	☐ Sinusitis _____
☐ Convulsions _____	☐ High Fever _____	☐ Tinnitus _____
☐ Croup _____	☐ Influenza _____	☐ Tonsillitis _____
☐ Dizziness _____	☐ Mastoiditis _____	☐ Vision Problems_____
☐ Draining Ear _____	☐ Measles _____	
☐ Ear Infections _____	☐ Meningitis _____	

☐ Other(s): _____

Please list any medications your child is currently taking including any herbal medications, vitamins or supplements: (Include: name, dose, frequency, and route of intake)_____

_____

_____

Is your child up to date with all vaccinations? ☐ Yes ☐ No If No, please explain _____

_____

Does your child have a diagnosis of the following? If yes, please provide age of onset:

☐ Autism _____	☐ Learning Disabilities_____	☐ Stuttering_____
☐ ADHD _____	☐ Hearing Loss_____	☐ Other _____
☐ Dyslexia _____	☐ Sensory Processing_____	

SURGERIES HOSPITALIZATIONS

Please list any prior surgeries and hospitalizations with approximate date(s):

- _____
- _____
- _____
- _____
- _____

GROWTH DEVELOPMENT

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

Crawl_____Sit_____Stand_____

Walk_____Feed Self_____Dress Self_____

Use Toilet _____

Use Single Words (e.g. no, mom, doggy, etc.) _____

Use Simple Questions (e.g. Where's doggy? etc.)_____

Engage in Conversation _____

Does your child have difficulty participating in activities that require large muscle coordination (e.g. walking, running)? ☐ Yes ☐ No If Yes, please specify:_____

_____

Does your child have difficulty participating in activities that require fine motor coordination (e.g. picking up objects between thumb and finger, writing) ☐ Yes ☐ No If Yes, please specify:____

_____

ORAL MOTOR FEEDING	Are there currently or have there been any feeding problems (e.g. problems sucking, swallowing, drooling, chewing, etc.)? ☐ Yes ☐ No If Yes, please describe:_____ _____ _____ Does your child follow a special diet? (gluten-free, casein-free, etc.) ☐ Yes ☐ No If Yes, please describe_____
HEARING	Describe your child's response to sound (e.g. responds to all sounds, responds inconsistently, etc.) _____ Has your child ever failed a hearing screener? ☐ Yes ☐ No If Yes, please describe: _____
ACADEMIC HISTORY	What school does your child attend? _____ Grade _____ How is your child performing academically (or pre-academically)? _____ _____ Does your child interact and engage with others at school? ☐ Yes ☐ No If No, please describe _____ _____ Does your child exhibit any behaviors and if so, what are typical triggers for behavior, and what does your child respond to in order to de-escalate? ☐ Yes ☐ No _____ _____ _____ Does your child receive special services at school (e.g. 504 plan)? ☐ Yes ☐ No If Yes, please specify_____ _____ If enrolled for special education services, has an Individualized Education Plan (IEP) been developed? ☐ Yes ☐ No If Yes, please describe the most important goals _____ _____ _____ _____ Please provide any additional information that might be helpful in the evaluation or remediation of your child's problem _____ _____ _____ _____ Please include any additional comments that would be helpful for your child's therapist to get to know him/her (i.e. motivators, interests, etc.)_____ _____

Person completing this form: _____

Relationship to child: _____ Date: _____

*If receiving this form electronically prior to your visit, please remember to bring any previous speech and language evaluation reports or related documentation.