2017 PARENT/CAREGIVER QUESTIONNAIRE

GENERAL INFORMATION **Date:** _____

Child's Name: _____ Age: _____

Date of Birth: _____ Sex: _____

Mother's Occupation: _____ Level of Education: _____

Father's Occupation: _____ Level of Education: _____

PATIENT HISTORY

Why is your child here today?

_____

When was the problem first noticed? _____

Is your child aware of the problem? ☐ Yes ☐ No

If yes, how does your child feel about it?

_____

How would you describe your child? _____

_____

FAMILY INFORMATION

List all people in household:

Name	Age	Sex	Grade	Relation

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

If yes, please describe: _____

What languages does your child speak? _____

HEALTH & MEDICAL HISTORY

Has your child ever been examined by any other professionals? ☐ Yes ☐ No

Who	Date Seen	Findings/Results
Neurologist		
ENT		
GI		
Developmental Pediatrician		
Pediatrician		

Is your child currently on any medications? ☐ Yes ☐ No

Name	Dosage	Frequency	Purpose

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

_____

Please list any health conditions, surgeries, etc. of note:

_____

_____

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 hearing been tested? ☐ Yes ☐ No

If yes, when? Results? _____

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

If yes, please list: _____

Were there any noticeable changes in your child's general behavior or speech after certain life events, illnesses, surgeries, etc.? ☐ Yes ☐ No

If so, explain: _____

_____

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

To Latex? ☐ Yes ☐ No

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

_____

_____

_____

_____

BIRTH HISTORY

Is the child adopted? ☐ Yes ☐ No

At what age? _____

Were there any complications or illnesses that occurred during pregnancy? ☐ Yes ☐ No

Was any medication taken during pregnancy? ☐ Yes ☐ No

If yes, please list: _____

Weight at birth _____ Was s/he full-term? ☐ Yes ☐ No

Type of Birth: ☐ Normal ☐ Induced

☐ Forceps ☐ Caesarean

☐ Premature (at _____ weeks)

Any specific problems/issues at birth)? ☐ Yes ☐ No

If yes, please list:

_____

How would you describe your child's 1st year? _____

_____

DEVELOPMENTAL HISTORY

Were developmental milestones met on time? ☐ Yes ☐ No

Which milestones were met on time?

- ☐ Sits unsupported
- ☐ Eats solid foods
- ☐ Crawls
- ☐ Stands alone
- ☐ Babble
- ☐ Say 1st word
- ☐ Walks
- ☐ Self-feeds
- ☐ Dresses self
- ☐ Bladder/bowel trained
- ☐ Use 2 word combos
- ☐ Say Complete sentences

Were any milestones delayed? ☐ Yes ☐ No

If yes, please list: _____

Does your child show aversive reaction to touching certain objects or textures? (check all that apply)

- ☐ on hands
- ☐ on mouth/lips
- ☐ on face
- ☐ toothbrush
- ☐ on feet
- ☐ on body
- ☐ inside mouth
- ☐ hair brush

When did teeth erupt? _____

Last visit to dentist? _____

Bruxism? ☐ Yes ☐ No

Thumbsucking? ☐ Yes ☐ No

Pacifer? ☐ Yes ☐ No

If yes, please describe: _____

When did s/he ended the use of pacifier? _____

SPEECH & LANGUAGE HISTORY

How does your child communicate? (check all that apply)

- ☐ Eye contact
- ☐ Gestures
- ☐ Jargon
- ☐ PECS symbols
- ☐ Words
- ☐ Sentences
- ☐ Writing
- ☐ Moves person/adult
- ☐ Vocalizations
- ☐ Sign Language
- ☐ AAC device
- ☐ Phrases
- ☐ Conversation

Other: _____

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

_____

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

Did speech learning ever seem to stop for a period? ☐ Yes ☐ No

If so, describe:

_____

Can your child follow directions? ☐ Yes ☐ No ☐ 1 step direction ☐ 2 steps ☐ 3 steps

Does s/he seem to have any hearing or visual problems? ☐ Yes ☐ No

_____

Please rate your child's attention:	**Good**	**Fair**	**Poor**
Preferred tasks	☐	☐	☐
Non Preferred tasks	☐	☐	☐
Academic tasks	☐	☐	☐
During interactions with others	☐	☐	☐

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

_____

FEEDING DEVELOPMENT/HISTORY

Were there any feeding problems in early life? ☐ Yes ☐ No

If so, describe:

_____

Are there any present eating problems? ☐ Yes ☐ No

If so, describe:

_____

Does s/he have difficulty chewing or swallowing? ☐ Yes ☐ No

Does s/he drool? ☐ Yes ☐ No

Is your child a picky eater? ☐ Yes ☐ No

How many foods does your child eat? ☐ Yes ☐ No

How many food items are in your child's diet?

<5

What are your child's favorite foods?

_____

Is there anything your child refuses to eat?

_____

Does your child use utensils? ☐ Yes ☐ No ☐ with prompts ☐ able to but prefers not to

Do they feed themselves? ☐ Yes ☐ No

If fed, who feeds the child:

_____

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

More information on feeding:

_____

_____

_____

Are mealtimes difficult? ☐ Yes ☐ No

Will she/he try new foods? ☐ Yes ☐ No

Intake as Infant

Method (check all that apply):

☐ Breast

☐ Bottle (Type of bottle: _____)

☐ Nipple (Type of nipple: _____)

Position of infant for feeding: _____

Average intake per feeding: _____ ounces in _____ minutes

Average intake per day: _____

Type of formula: _____

Constipation? ☐ Yes ☐ No

If yes, please describe how it was treated: _____

_____

Reflux? ☐ Yes ☐ No

If yes, please describe how it was treated: _____

_____

EDUCATIONAL HISTORY

Name of current school: _____

Current grade: _____

Has your child repeated a grade? ☐ Yes ☐ No

Which one? _____

Indicate performance level in school: below average

Did child attend nursery school and/or pre-K? ☐ Yes ☐ No

If yes, where? _____

Does your child like school? ☐ Yes ☐ No

Does your child receive any of the following services through an:

☐ EIP ☐ Tutoring

☐ IEP ☐ 504 plan

THERAPY:

Please provide information on therapies your child currently receives.

Therapy	Type	Frequency	Therapist Name
OT			
PT			
ABA			
Floor Time			
Music			
Nutrition			
Other			

BEHAVIOR/SOCIAL:

Who does your child prefer to play with?

☐ Alone ☐ with older kids

☐ with peers ☐ with younger kids

Does your child have close friends? ☐ Yes ☐ No

Does your child prefer to play alone or with others?

_____

What are your child's most frequent discipline problems?

_____

Who disciplines in the family?

_____

How is the child disciplined?

_____

What does the child do well?

_____

What does your child have trouble doing?

_____

OTHER COMMENTS:

_____

_____

_____

_____

_____