Innovative Therapy Services

Pediatric Speech-Language Services

Expect the best in learning Speech, Language and Social Skills

Toddler Questionnaire

General Information

Child's Name: ____________________________ Date of Birth: ____________

Address: ________________________________ Phone: ________________

City: ___________________________________ Zip Code: ______________

Does the Child Live with Both Parents? _______________________________

Mother's Name: ___________________________ Age: _________________

Mother's Occupation: _______________________ Business Phone: __________

Father's Name: ____________________________ Age: _________________

Father's Occupation: ________________________ Business Phone: __________

Referred by: ______________________________ Phone: ________________

Address: ____

Pediatrician: ______________________________ Phone: ________________

Address: ____

Family Doctor: ____________________________ Phone: ________________

Address: ____

List the people who live with the child now, age, relationship, occupation/school grade:

____

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What languages does the child speak? What is the child's dominant language?

What languages are spoken in the home? What is the dominant language spoken?

History of the speech and language problem

Describe the main problem/speech-language issues for which you are seeking help.

When was the problem first noticed? By whom?

What do you think may have caused the problem?

Has the problem changed since it was first noticed? Please describe.

How does the child usually communicate? (gestures, single words, short phrases, sentences?)

How does your child get your attention?

How does your child communicate wants and needs?

How does the problem affect the child's behavior/attitude?

What are your expectations from therapy? What are your goals for the child?

Have any other speech–language specialists seen the child? Who and when? What were their conclusions or suggestions?

Have any other specialists (physicians, audiologists, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

Are there any other speech, language, or hearing problems in your family? If yes, please describe.

Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents, medications, etc.).

Length of pregnancy:______________________Length of labor:____________________

General condition:________________________Birth weight:_______________________

Circle type of delivery: head first feet first breech Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth? Please describe.

Medical History

Provide approximate ages at which the child suffered the following illnesses and conditions:

Asthma________________Chicken Pox______________Colds____________________

Croup__________________Dizziness_________________Draining Ear_______________

Ear Infections___________Encephalitis_______________German Measles___________

Headache______________High Fever________________Influenza_________________

Mastoiditis______________Measles__________________Meningitis________________

Mumps________________Pneumonia_______________Seizures_________________

Sinusitis________________Tinnitus__________________Tonsillitis_________________

Other____

Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy, tube placement)?

Describe any major accidents or hospitalizations.

Is the child taking any medications? If yes, identify.

Have there been any negative reactions to medications? If yes, identify.

Does the child have allergies? If yes, please list each allergen and describe the child's response to contact with the allergen.

Please describe immediate action to be taken in case of contact with allergen(s).

Developmental History

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

Crawl_____________Sit________________Stand_____________Walk_______________

Feed self__________Dress self__________Use toilet___________Babbled____________

First Word__________Turn to find Sound___________Turn to find Voice__________________

Recognize name of Familiar Person________________Recognize name of Object___________

Follow a simple direction__________________

Yes No Does your child imitate facial expressions?

Yes No Does your child imitate speech sounds?

Yes No Does your child imitate behaviors he or she observed at an earlier time (not immediately following the model)?

Yes No Can your child point to common objects when you name them (e.g. using picture books)?

Yes No Does your child understand you when you talk to him or her?

Yes No Does your child answer simple questions?

Yes No Does your child respond to simple commands (e.g. "Get your cup")?

Yes No Does your child maintain eye contact with you?

Yes No Does your child smile?

Yes No Does your child play well with others?

Yes No Does your child seem to understand the functions of objects (e.g. a cup Is for drinking, a brush is for brushing hair)?

Yes No Does your child ask questions?

With whom does your child spend a majority of the day?

What kinds of play activities does your child engage in?

Describe a typical day (include details):

Does the child have difficulty running, walking, or participating in other activities that require small or large muscle coordination?

Are there or have there ever been any feeding problems (e.g. problems with sucking, swallowing, drooling, chewing)? If yes, please describe.

Educational History

List the daycare/preschools that the child has attended or is currently attending.

School attended	Duration of Enrollment	Teacher

Are there any academic difficulties reported? By whom? Please describe.

Are there any behavioral difficulties reported? By whom? Please describe.

Please describe your child's interaction with his/her teachers and classmates.

Family-Social History

Please tell us about your family leisure-time activities.

What are your child's favorite toys/activities?

Please describe how the child relates to his/her siblings.

Does your child have playmates? Describe their play and how your child interacts with others (e.g. shy, aggressive, etc.). What are their ages?

What is your mode of discipline?

Person completing form:____

Relationship to the child:____

Signed:_________________________________Date:_______________________