



Innovative Therapy Services

Pediatric Speech-Language Services

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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:

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 child's speech–language problem

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 the 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 _____

Headaches _____ 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_____ Babble_____ First word_____

Turn to find sound_____ Turn to find a 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 walking, running, 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, 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. What are their ages?

What is your mode of discipline?

Person completing form: _____

Relationship to the child: _____

Signed: _____ Date: _____