Innovative Therapy Services

Pediatric Speech-Language Services



Expect the best in learning Speech, Language and Social Skills

1090 Homestead Road Santa Clara, CA 95050 Ph (408) 241-2229 Fax (408 241-3156 www.pediatricspeech.com

School-Age Child 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:	
Address:	
	Phone:
Address:	
List the people who live with the child n	ow, age, relationship, occupation/school grade:
What languages does the child speak?	What is the child's dominant language?
What languages are spoken in the hom	e? 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 the problem affect the child's behavior/attitude? Describe how the problem has impacted the family. 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 teachers, etc.) seen the chand the specialist's conclu	nild? If yes, inc	licate the type o		
Are there any other speec please describe.	h, language, oi	r hearing proble	ms in your family? I	f yes,
Prenatal and Birth Histor	ry			
Mother's general health du	ıring pregnanc	y (illnesses, acc	idents, medications,	etc.).
Length of pregnancy:		Length	of labor:	
General condition:				
Circle type of delivery:	head first	feet first	breech	Caesarian
	\bigcirc	\bigcirc	\bigcirc	\bigcirc
Were there any unusual confidence describe.	onditions that r	may have affecto	ed the pregnancy or	birth?
Provide the approximate a	ge at which the	e child began to	do the following act	ivities:
Crawl	Sit		Stand	
Walk	Feed self		Dress self	
Use toilet	_ Use single \	words (e.g., no,	mom, doggie)	
Combine words (e.g., me Name simple objects (e.g. Use simple questions (e.g.	, dog, car, tree ., Where's dog	ggie?)	<u> </u>	
Engage in a conversation				

Medical Histo	ry
---------------	----

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.

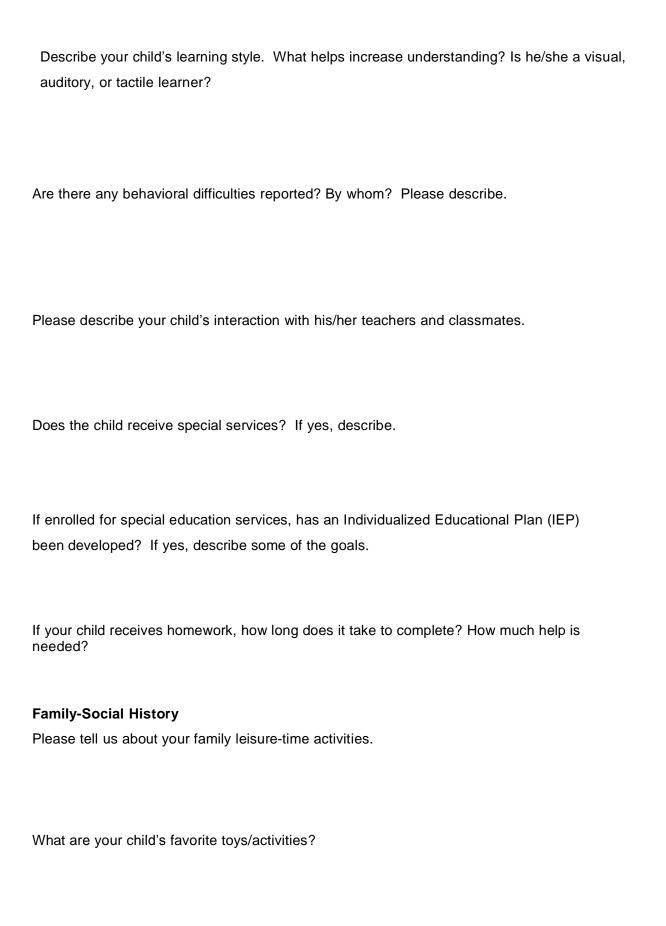
Please describe immediate action to be taken in case of contact with allergen(s).

Educational History

List the schools that the child has attended or is currently attending.

School attended	District/City	Grade level

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



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?
Describe any behavioral or emotional issues.
Describe your child's strengths and unique qualities.
Person completing form:
Relationship to the child:
Signed:Date: