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## Parent / Guardian Questionnaire

Date: _____

**General Information:**

Child's Name: _____

Child's Date of Birth: _____ Age: _____

Home Phone Number: _____

Address: _____
Street City, State Zip Code

Sibling(s) and Age(s): _____

Parent(s) / Guardian(s) Name(s): _____

_____

Parent(s) / Guardian(s) E-mail(s): _____

_____

Parent(s) / Guardian(s) Work Number(s): _____
Number Name

_____
Number Name

Parent(s) / Guardian(s) Cell Number(s): _____
Number Name

_____
Number Name

Parent(s) / Guardian(s) Occupation(s): _____
Occupation Name

_____
Occupation Name

Are there any other adults in the home? If so, whom:

_____

Have other siblings or family members experienced speech / language difficulties? If so, whom:

_____

What languages are spoken in the home?

_____

Emergency Contact (other than those adults listed above):

_____

Name Number

**Service Provider Information:**

Physician's Name: _____

Physician's Phone Number: _____

Dentist's Name: _____

Dentist's Phone Number: _____

Orthodontist's Name: _____

Orthodontist's Phone Number: _____

Additional Service Provider's Name: _____

Service Provider's Area of Practice: _____

Service Provider's Phone Number: _____

Additional Service Provider's Name: _____

Service Provider's Area of Practice: _____

Service Provider's Phone Number: _____

Additional Service Provider's Name: _____

Service Provider's Area of Practice: _____

Service Provider's Phone Number: _____

**Statement of Problem:**

Please describe your child's speech / language / auditory problem:

_____

_____

When was the problem first noticed? _____

_____

How has the problem changed / evolved? _____

_____

What strategies have been used at home that seem to help? _____

_____

_____

What professional services has your child received and when? _____

_____

_____

If testing has been done, what skills were assessed? _____

_____

**Speech, Language, and Hearing History:**

As an infant, did your child babble and play with sounds? Yes ❑ No ❑

When did your child speak his/her first word? _____

When did your child begin using two-word phrases? _____

How does your child mainly communicate? (choose one)

Sentences ❑ Phrases ❑ 1-2 Words ❑ Sounds ❑ Gestures ❑

Please give examples: _____

_____

What % of your child's verbal communication can be understood by you? _____%

What % of your child's verbal communication can be understood by siblings? _____%

What % of your child's verbal communication can be understood by friends? _____%

What % of your child's verbal communication can be understood by strangers? _____%

How does your child react to hearing speech? _____

_____

How does your child react to environmental sounds? _____

_____

Please describe how your child follows directions? _____

_____

Has your child's speech / language been tested in the past 6 months? Yes ❑ No ❑

If yes, by whom: _____

Has your child's hearing been tested in the past year? Yes ❑ No ❑

If yes, by whom: _____

Has your child's vision been tested in the past year? Yes ❑ No ❑

If yes, by whom: _____

**Social / Behavior:**

Does your child:

| | | | | | |
|---|---|---|---|---|---|
| Make eye contact? | Yes ❑ | No ❑ | Give information? | Yes ❑ | No ❑ |
| Respond on topic? | Yes ❑ | No ❑ | Make requests? | Yes ❑ | No ❑ |
| Interrupt appropriately? | Yes ❑ | No ❑ | Apologize? | Yes ❑ | No ❑ |
| Stay on topic? | Yes ❑ | No ❑ | Protest? | Yes ❑ | No ❑ |
| Tell you the names of things? | Yes ❑ | No ❑ | Show humor? | Yes ❑ | No ❑ |
| Tell you how things are used? | Yes ❑ | No ❑ | Solve problems verbally? | Yes ❑ | No ❑ |
| Describe things and actions? | Yes ❑ | No ❑ | Greet people? | Yes ❑ | No ❑ |
| Ask for information? | Yes ❑ | No ❑ | | | |

Is your child:

Competitive? Yes ❑ No ❑
Sensitive to criticism? Yes ❑ No ❑
Perfectionistic? Yes ❑ No ❑
Mature for his/her age? Yes ❑ No ❑
Overly sensitive to touch? Yes ❑ No ❑
Overly sensitive to sound? Yes ❑ No ❑

What are your child's favorite play activities? _____

_____

Does your child play alone or with other children? _____

How does s/he get along with other children? _____

How does s/he get along with adults? _____

Is it difficult to discipline your child? Yes ❑ No ❑

Please give examples: _____

_____

How would you describe your child? _____

_____

**Birth and Developmental Information:**

Age of parents at the time of your child's birth: Mother _____ Father _____

Is your child adopted? Yes ❑ No ❑

If yes, what was your child's age at adoption: _____

How was the mother's health during pregnancy? _____

_____

Was your child full-term at birth? Yes ❑ No ❑

If no, how many weeks gestation at birth? _____

What was your child's birth weight? _____ lbs. _____ oz.

Please describe the delivery: _____

_____

Did your child have any birth injuries? Yes ❑ No ❑

If yes, please describe: _____

_____

Was your child jaundiced? Yes ❑ No ❑

Did your child require oxygen? Yes ❑ No ❑

Did your child have a heart murmur? Yes ❑ No ❑

Did your child have any difficulty nursing? Yes ❑ No ❑

Please describe your child's health during the first several months: _____

_____

Please indicate the ages at which your child accomplished the following:

Sat alone: _____ Walked alone: _____ Bladder trained: _____
Crawled: _____ Dressed self: _____ Bowel trained: _____
Stood alone: _____

Was your child's rate of growth seemingly normal? Yes ❑ No ❑

Was normal development interrupted by anything? Yes ❑ No ❑

If yes, please describe: _____

_____

Does your child have difficulty with gross or fine motor skills? Yes ❑ No ❑

If yes, please describe: _____

_____

**Feeding History:**

Was your child breast-fed or bottle-fed? _____

If breast-fed, long? _____ yrs. _____ mos. If bottle-fed, long? _____ yrs. _____ mos.

Were there any early feeding problems, such as colic, special formula, or difficulty making the transition to table food? Yes ❑ No ❑

If yes, please describe: _____

_____

Does s/he drink more than one glass of liquid with meals? Yes ❑ No ❑

Does s/he appear to wash down food? Yes ❑ No ❑

Is s/he a fast or slow eater? Fast ❑ Slow ❑

Does s/he chew food adequately? Yes ❑ No ❑

Does s/he belch excessively? Yes ❑ No ❑

Does s/he have frequent digestive problems? Yes ❑ No ❑

Does s/he choke easily? Yes ❑ No ❑

Does s/he resist foods that are difficult to chew? Yes ❑ No ❑

Does s/he eat a variety of foods? Yes ❑ No ❑

Does s/he eat a variety of textures? Yes ❑ No ❑

Does s/he eat a variety of temperatures? Yes ❑ No ❑

Does s/he eat a variety of flavors? Yes ❑ No ❑

Is s/he on a special diet? Yes ❑ No ❑

If yes, please describe: _____

_____

**Medical History:**

Age Severity

Tonsillitis: _____

Tonsillectomy: _____

Adenoidectomy: _____

Lingual Frenectomy: _____

Middle Ear Infections: _____

Earaches: _____

Ear Surgery: _____

Hearing Loss: _____

Heart Problems: _____

High Fevers / Measles: _____

Mumps: _____

Pneumonia: _____

Frequent Colds: _____

Upper Respiratory Infections: _____

Snoring: _____

Allergies: _____

Asthma: _____

Sinus Problems: _____

Headaches: _____

Seizures: _____

Head Injury: _____

Loss of Consciousness: _____

GERD (Acid Reflux): _____

Visual Difficulty: _____

Mumps: _____

Is your child currently under a physician's care? Yes ❑ No ❑

If yes, please list reason(s): _____

Is your child currently taking any medication(s)? Yes ❑ No ❑

If yes, please list medication(s): _____

Other medical conditions not mentioned: _____

Is there smoking in the home? Yes ❑ No ❑

Is your child's general health good? Yes ❑ No ❑

Other injuries or surgeries: _____

**Dental History:**

Has your child ever sucked his or her thumb or fingers? Yes ❑ No ❑

If yes, until what age? _____

Did your child use a pacifier? Yes ❑ No ❑ If yes, until what age? _____

Were baby teeth normal? Yes ❑ No ❑

Were baby teeth lost at normal ages? Yes ❑ No ❑

Were baby teeth lost to accident or injury? Yes ❑ No ❑

Please list any tongues ties your child has had: _____

How often does your child brush his or her teeth daily? _____ times

How often does your child floss his or her teeth weekly? _____ times

Does your child have cavities or periodontal disease? Yes ❑ No ❑

Does your child clench or grind his or her teeth at night? Yes ❑ No ❑

Does your child clench or grind his or her teeth during the day? Yes ❑ No ❑

Does your child have any pain or clicking upon opening widely? Yes ❑ No ❑

Does your child have any pain or clicking upon chewing? Yes ❑ No ❑

Please describe any other facial pain your child may have: _____

_____

Does anyone in your family have similar dental conditions? Yes ❑ No ❑

Does your child have difficulty chewing, eating, and/or swallowing food? Yes ❑ No ❑

Does your child often have headaches? Yes ❑ No ❑ If yes, how often? _____

Please list any severe facial injuries: _____

Have permanent teeth been injured / chipped / lost? Yes ❑ No ❑

If yes, which teeth and when? _____

Please list any extra teeth your child may have: _____

If your child has seen an orthodontist, what has been done so far? _____

_____

Please list any orthodontic appliances currently in place: _____

_____

Are adjustments still being made? Yes ❑ No ❑

When will the appliance(s) come off? _____

What does the orthodontist plan to do in the future? And when? _____

_____

If orthodontic treatment has been completed, how long were braces worn? _____

How long ago were braces removed? _____

What kind of retainer is worn? _____

In the past 6-12 months, occlusion has:

Gotten Better ❑ Gotten Worse ❑ Stayed the Same ❑

Please list any other family members who have:

Received orthodontic treatment: _____

Received treatment for feeding, swallowing, or tongue thrust issues: _____

**Associated Oral Behaviors:**

Does your child breath through mouth, nose, or both? _____

When watching TV, riding in the car, or sleeping, your child's mouth is:

Open ❑ Closed ❑ Both ❑

Does s/he bite fingernails? Yes ❑ No ❑

Does s/he chew on pencils, shirt, etc.? Yes ❑ No ❑

Does s/he lick lips excessively? Yes ❑ No ❑

Are his or her lips chapped much of the time? Yes ❑ No ❑

Does s/he prop chin on palm or fist? Yes ❑ No ❑

Does s/he chew gum excessively? Yes ❑ No ❑

**Educational Information:**

School: _____

Address: _____

Street City, State Zip Code

Child's Grade Level: _____ Teacher's Name: _____

Does your child excel in any subjects / areas? Yes ❑ No ❑

If yes, which subjects / areas? _____

Does your child struggle in any subjects / areas? Yes ❑ No ❑

If yes, which subjects / areas? _____

Does s/he read at grade level? Yes ❑ No ❑ Does s/he enjoy reading? Yes ❑ No ❑

Does s/he spell at grade level? Yes ❑ No ❑ Does s/he enjoy writing? Yes ❑ No ❑

Has your child been in Speech, Language, Reading, Special Ed., etc.? Yes ❑ No ❑

If yes, which one(s)? _____

If yes, what was / is the teacher's name? _____

Name Program

If yes, what was / is the teacher's name? _____

Name Program

If yes, what was / is the teacher's name? _____

Name Program

**Other Factors:**

If you were to indicate factors that may be related to your child's problem, which ones would you include? Please check the box next to as many as you think apply.

- ❑ Anxiety / Nervousness
- ❑ Autism
- ❑ Behavior Problem
- ❑ Birth Injury / Trauma
- ❑ Brain Injury
- ❑ Cerebral Palsy
- ❑ Difficulties with Attention
- ❑ Emotional
- ❑ Environmental Problems
- ❑ Epilepsy
- ❑ Family Trauma
- ❑ Feeding Problems
- ❑ Genetics / Heredity
- ❑ Hearing Loss
- ❑ Inconsistency in Parenting
- ❑ Intellectual Difficulties
- ❑ Lack of Playmates
- ❑ Neglect by Father
- ❑ Neglect by Mother
- ❑ Overprotection by Father
- ❑ Overprotection by Mother
- ❑ Recent Move
- ❑ Sensory Integration
- ❑ Shyness
- ❑ Sibling Rivalry
- ❑ Slow Development
- ❑ Stubbornness
- ❑ Visual Disturbances

**Questions & Additional Information:**

Are there specific questions you would like answered about your child?

_____

_____

_____

_____

_____

_____

_____

_____

Is there anything else about your child or your family that I should know that might help me provide better service?

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to fill out this questionnaire.