thera kids associates

PARENT/CAREGIVER QUESTIONNAIRE

Name of Child_____ **Child's Date of Birth**_____

Name of Parent(s)/**Legal Guardian**(s) _____

Parent/Guardian's Email Address_____

Mailing Address _____

Home Phone _____ **Mobile Phone** _____

Child's Physician _____ **Phone** _____

Who recommended that your child be evaluated?_____

FAMILY HISTORY

Mother's Name_____ **Occupation**_____

History of speech, language, or learning problems? ☐ Yes ☐ No

Please explain problems if applicable. _____

Father's Name_____ **Occupation**_____

History of speech, language, or learning problems? ☐ Yes ☐ No

Please explain problems if applicable. _____

Who currently lives at home? _____

Please provide additional family histories (including grandparents, siblings, aunts, uncles) **of the following:**

Family Member_____ Family Member _____

Speech Disorder_____ Reading Disability _____

Learning Difficulties _____ Hearing Loss _____

Seizures _____ Anxiety _____

Depression _____ Substance Abuse _____

PRENATAL & BIRTH HISTORY

Age During Pregnancy_____ **Type of Delivery** _____

List any maternal injuries, specific illnesses, or other medical complications diagnosed during pregnancy:

_____

_____

Were there any complications during labor and delivery for the mother?

_____

_____

Were there any complications during labor and delivery for the baby?

_____

_____

Were there any problems experienced by baby after birth? ☐ Yes ☐ No

If so, what were the causes and treatments?_____

_____

_____

MEDICAL HISTORY

Please list any previous and/or present illnesses, surgeries, injuries, and treatment(s) **your child has had:**

List medications your child is currently taking and why.

AUDIOLOGICAL HISTORY

Does your child have a history of ear infections?

If so, please list ages and number of infections.

What treatment, if any has your child received for ear infections?

Do you think your child has a hearing problem? ☐ Yes ☐ No

If yes, please describe the behaviors that lead you to suspect a hearing problem.

Has your child's hearing been tested? ☐ Yes ☐ No

If so, please list where, when and results.

Does your child wear a hearing aid(s)**?** ☐ Yes ☐ No

If so, which ear? _____

SPEECH LANGUAGE DEVELOPMENT

At what age did your child make:

Cooing sounds _____ Babbling sounds _____ (baba)

Jargon_____ (sounds like real words but isn't)

Single words_____ Two-three words _____

Phrases _____

How does the child make his/her needs/wants known?

☐ Gestures ☐ Cries ☐ Points

☐ Pulls to lead you ☐ Looks at objects ☐ Grabs/touches objects/people

☐ Sounds ☐ One-three words ☐ Sentences

Is your child's speech understood? ☐ Yes ☐ No

Is your child's speech only understood by family? ☐ Yes ☐ No

Is your child difficult to understand by others? ☐ Yes ☐ No

Does your child repeat words or sounds in words (stutter)**?** ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

Does your child have trouble saying particular sounds? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Does your child know his or her name? ☐ Yes ☐ No

Does your child imitate sounds, words and gestures? ☐ Yes ☐ No

Does your child follow directions? ☐ Yes ☐ No

Does your child answer yes/no questions correctly? ☐ Yes ☐ No

Does your child identify familiar objects and pictures in book? ☐ Yes ☐ No

Does your child respond when in another room? ☐ Yes ☐ No

Does your child appear aware of or frustrated by his or her speech and/or language difficulties? ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

Have other people noticed that your child may have speech and language difficulties? ☐ Yes ☐ No

If so, who has shared this information with you and what has been noted?

_____

_____

_____

Has your child received a Speech and Language Screening or Evaluation? ☐ Yes ☐ No

If yes, where, when and what were the results?

_____

_____

_____

Has your child received Speech-Language therapy or other therapies? ☐ Yes ☐ No

If yes, where, for what reasons, and for how long?

_____

_____

_____

SOCIALIZATION/EMOTIONAL DEVELOPMENT

Is your child able to separate from primary caregiver? ☐ Yes ☐ No

How does your child get along with caregivers?

How does your child get along with other children?

How does your child respond to new situations, people and places?

Describe your child's reaction to discipline:

Does your child have any perseverative/ritualistic behaviors? ☐ Yes ☐ No

If yes, please describe:

Check behavior(s) that your child may exhibit:

- ☐ Timid
- ☐ Avoids change
- ☐ Overly active
- ☐ Overly quiet
- ☐ Easily frustrated
- ☐ Frequently tantrums
- ☐ Difficult to console
- ☐ Gets along with other children
- ☐ Friendly
- ☐ Prefers interacting with adults or older children
- ☐ Prefers to play alone
- ☐ Plays well with other children
- ☐ Says hello and good bye
- ☐ Takes turns
- ☐ Trouble sharing
- ☐ Has trouble making eye contact
- ☐ Inflexible thinking
- ☐ Only talks about his/her own ideas
- ☐ Difficulty compromising
- ☐ Trouble cooperating
- ☐ Destructive
- ☐ Trouble following rules

Please check your child's favorite toys and activities:

- ☐ Looking through books
- ☐ Rough and tumble play
- ☐ Combinatorial play (blocks, LEGO, etc.)
- ☐ Pretend play (role-play "house", "restaurant")
- ☐ Pretend play with toy objects, and characters (zoo, zoo animals, paw patrol)
- ☐ Games with rules (board games)

Check all behaviors that apply to your child:

- ☐ Carries toys around but does not play with them
- ☐ Throws toys
- ☐ Does not play with pretend play with props/toys appropriately (mouths, bangs toys together, moves toys repetitively along surfaces)

FEEDING/EATING

Has your child breast or bottle fed? _____ **Age weaned** _____

Were there any difficulties with:

☐ Sucking/nursing ☐ Swallowing ☐ Reflux

Did your child have early difficulties with gagging, choking, chewing or swallowing?

If yes, please describe:

_____

_____

_____

Any present difficulties with feeding?

If yes, please describe:

_____

_____

_____

When were solid foods introduced? _____

Is your child a "picky eater" with preference for or avoidance of any food types, textures, temperature, or tastes?

If yes, please describe:

_____

_____

_____

Does your child have difficulties using a:

☐ Spoon ☐ Fork ☐ Cup

If yes, please describe:

_____

_____

_____

Does or did your child use a pacifier? ☐ Yes ☐ No

If yes, for how long? _____

MOTOR DEVELOPMENT

At what age did your child:

Roll over _____ Sit without support _____ Crawl_____

Stand _____ Walk _____ Eat food with fingers_____

Eat with spoon _____ Drink from open cup _____ Toilet train_____

(Un)Dress him/herself _____

EDUCATION

Name of School (if appropriate) _____

Grade level (if appropriate) _____

Attends _____ days per week

Name of teacher(s) _____

Has your child's teacher(s) **contacted you about any concerns?** _____

If yes, please describe concerns and school's recommendations:

_____

_____

_____

Please include any additional information you want to share that may help us help your child.

_____

_____

_____

Submit