



2019 PARENT/CAREGIVER QUESTIONNAIRE

GENERAL INFORMATION

Date: _____

Child's Name: _____

Age: _____

Date of Birth: _____

Sex: _____

Mother's Occupation: _____

Level of Education: _____

Father's Occupation: _____

Level of Education: _____

PATIENT HISTORY

Why is your child here today?

When was the problem first noticed? _____

Is your child aware of the problem? Yes No

If yes, how does your child feel about it? _____

How would you describe your child? _____

FAMILY INFORMATION

List all people in household:

Name	Age	Sex	Grade	Relation

Does anyone else in the family have speech, language, or hearing problems? Yes No

If yes, please describe: _____

What languages does your child speak? _____

HEALTH & MEDICAL HISTORY

Has your child ever been examined by any other professionals?

Yes

No

	Doctor	Practice	Date	Diagnosis Given/Results Found
Neurologist				
ENT				
GI				
Developmental Pediatrician				
Pediatrician				

Is your child currently on any medications?

Yes

No

Medication	Dosage	Frequency	Purpose

Please describe your child's general health. _____

Please list any health conditions, surgeries, etc. that you consider significant/relevant: _____

Has your child had his/her tonsils and adenoids removed?

Yes

No

Has your child had any ear trouble (earaches, infections)?

Yes

No

How many? _____

Has hearing been tested?

Yes

No

If yes, when? Results? _____

Has your child ever had (PE) tubes inserted?

Yes

No

If yes, when? _____

Has your child had their vision tested?

Yes

No

Has your child ever worn glasses?

Yes

No

Does your child currently wear glasses?

Yes

No

Does your child have dental problems?

Yes

No

Has your child ever had a seizure(s)?

Yes

No

If so, are these treated with medicine?

Yes

No

If yes, please list: _____

—

Were there any noticeable changes in your child's general behavior or speech after a certain life event, illness, surgery, etc.?

Yes

No

If so, explain: _____

Does your child have any known **skin** allergies?

Yes

No

Latex allergy?

Yes

No

Does your child have any **food** allergies or is s/he on a restricted diet? If so, please explain:

BIRTH HISTORY

Is your child adopted?

Yes

No

At what age? _____

Does your child know s/he is adopted?

Yes

No

Were there any complications or illnesses that occurred during pregnancy?

Yes

No

Was any medication taken during pregnancy?

Yes

No

If yes, please list: _____

Weight at birth _____

Was s/he full-term?

Yes

No

Type of Birth:

Normal

Induced

Forceps

Caesarean

Premature (at ____ weeks)

Any specific problems/issues at birth?

Yes

No

If yes, list: _____

How would you describe your child's 1st year? _____

DEVELOPMENTAL HISTORY

Were developmental milestones met on time? Yes No

Which milestones were met on time?

Sits unsupported	Walks
Eats solid foods	Self-feeds
Crawls	Self-feeds
Stands alone	Bladder/bowel trained
Babble	Use 2 word combos
Say 1 st word	Say Complete sentences

If milestones were delayed, please elaborate: _____

Does your child show aversive reaction to touching certain objects or textures? (Check all that apply).

on hands	on feet
on mouth/lips	on body
on face	inside mouth
toothbrush	hair brush

When did teeth erupt? _____

Last visit to dentist? _____

Bruxism? Yes No

Thumbsucking? Yes No

Pacifier? Yes No

If yes, please describe usage: _____

When did you discontinue pacifier usage? _____

SPEECH & LANGUAGE HISTORY

How does your child communicate? (check all that apply)

Eye contact	Moves person/adult
Gestures	Vocalizations
Jargon	Sign Language
PECS symbols	AAC device
Words	Phrases
Sentences	Conversation
Writing	Other: _____

What efforts does your child make to communicate his/her wants when not understood?

Is your child's speech understandable to: family? friends?
strangers?

Did speech learning ever seem to stop for a period? Yes No

If so, describe: _____

Can your child follow directions?	Yes	No	1 step direction	
			2 steps	
			3 steps	
Please rate your child's attention:	Good		Fair	Poor
Preferred tasks				
Non Preferred tasks				
Academic tasks				
During interactions with others				
What have you done to help your child's speech and language?	_____			

FEEDING DEVELOPMENT/HISTORY

Were there any feeding problems in early life?	Yes	No		
If so, describe: _____				
Are there any current eating problems?	Yes	No		
If so, describe: _____				
Does s/he have difficulty chewing or swallowing?	Yes	No		
Does s/he drool?	Yes	No		
Is your child a picky eater?	Yes	No		
How many food items are in your child's diet?	<5	5-10	10-20	20+
What are your child's favorite foods?	_____			

Is there anything your child refuses to eat?	_____			
Does your child use utensils?	Yes	No		
Do they feed themselves?	Yes	No		
If not, who feeds the child: _____				
How does your child take in liquid?	Syringe	Bottle		
	Nuby Cup	Sippy cup		
	Straw	Cup		
Additional Comments on Feeding:	_____			

Are mealtimes difficult?	Yes	No		
Will s/he try new foods?	Yes	No		
Has your child ever had issues with:	Reflux	Constipation		
If yes, when? _____				

Intake as Infant (only applicable for children 5 and under)

Method (check all that apply):

Breast

Bottle (Type of bottle: _____)

Nipple (Type of nipple: _____)

Position of infant for feeding: _____

Average intake per feeding: _____ ounces in _____ minutes

Average intake per day: _____

Type of formula: _____

EDUCATIONAL HISTORY

Child's current school: _____

Please list all previous schools and years attended: _____

Current grade: _____

Has your child repeated a grade?

Yes

No

If yes, which grade? _____

Indicate performance level in school:

Below Average

Average

Above Average

Did child attend nursery school and/or pre-K?

Yes

No

If yes, where? _____

Does your child like school?

Yes

No

Does your child receive services through any of the following:

EIP

Tutoring

IEP

504 plan

If yes, please list services and frequency: _____

THERAPY:

Please provide information on therapies your child currently receives.

Therapy	Frequency	Therapist Name/Practice
Speech		
Feeding		
Occupational		
Physical		
ABA		
Floor Time		
Music		
Nutrition		
Other		

BEHAVIOR/SOCIAL:

Does your child play:

alone

with older children

with peers

with younger children

Does your child have close friends?

Yes

No

What are your child's most frequent discipline problems? _____

Who handles discipline? _____

How is the child disciplined? _____

Please list your child's strengths when interacting with peers: _____

Please list concerns you have about your child's interactions with peers: _____

OTHER COMMENTS:
