Milestone Pediatric Therapy Services, Inc
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ST Questionnaire

Background Information

Patient Name: _____ DOB: _____ Gender M__F__

Patient lives with (check one): __ Birth Parents__ Adoptive Parents __ Foster Parents

__ One Parent __ Parent and Step-Parent __ Siblings :

Is there a language other than English spoken in the home? _____ Yes _____ No

If yes, which one?

Does the child speak the language? _____ Yes _____ No

Does the child understand the language? _____ Yes _____ No

Who speaks the language?

Which language does the child prefer to speak at home?

What do you see as your child's most difficult problem in the home?

What do you see as your child's most difficult problem in school?

Does your child receive special education services at school? If yes, What services?

_____

How long have you been concerned? _____

Is your child aware/concerned/frustrated? _____

Pregnancy: _____Full-Term _____Premature

Was there anything unusual about the pregnancy or birth? _____ Yes _____ No

Birth History: _____Unremarkable _____Complications; please explain below:

Was the mother sick during the pregnancy? If yes, please describe:

Did the child go home with his/her mother from the hospital? _____ Yes _____ No

If child stayed at the hospital, please describe why and how long.

Medical History

Has your child had any of the following?

Adenoidectomy
Allergies
Breathing difficulties
Chicken pox
Colds
Ear infections
How often? _____

Ear tubes
Encephalitis
Flu
Head injury
High fevers
Measles
Meningitis
Mumps
Scarlet fever
Seizures
Sinusitis
Sleeping difficulties
Thumb/finger sucking
Tonsillectomy
Tonsillitis
Vision problems

Is your child currently (or recently) under a physician's care? _____ Yes _____ No

If yes, why?

Please list any medications your child takes regularly:

Please tell the approximate age your child achieved the following developmental milestones:

_____ sat alone _____ babbled _____ put two words together

_____ walked _____ grasped crayon/pencil _____ said first words

_____ short sentences _____ toilet trained

Did your child pass the infant hearing screening? _____ Yes _____ No

Previous therapy? _____ Yes _____ No

If yes, when?

Where?

Please provide medical records and authorization to release medical records.

Does your child…

- ☐ Repeat sounds, words or phrases over and over?
- ☐ Understand what you are saying?
- ☐ Retrieve/point to common objects upon request (ball, cup shoe)?
- ☐ Follow simple directions ("shut the door" or "get your shoes")?
- ☐ Respond correctly to yes/no questions?
- ☐ Respond correctly to who/what/where/when/why questions?

Your child currently communicates using…

- ☐ Body language
- ☐ Sounds (vowels , grunting)
- ☐ Words (shoe, doggy, up)
- ☐ 2 to 4 word sentences
- ☐ Sentences longer than four words

How many words are in your child's expressive vocabulary?

_____ 0-5 _____10-20 _____25-50 _____50+

Is your child difficult to understand? _____ to you _____ to an unfamiliar listener

Did your child suck their thumb or take a pacifier? Yes _____ No_____

If yes, how long?

Can your child blow bubbles/drink through a straw? Yes _____ No_____

Can your child suck through a straw? Yes _____ No_____

Does your child sound hoarse in the morning, at night, or when tired? Yes _____ No_____

Does your Child have sensitivities to:	Yes	No
Tags/Clothing		
Loud Noises		
Walking in sand/grass		
Getting their hands dirty		
Different textures in food		
Transitioning to new activities		
Is your child a picky eater		

Other information about your child's communication:

Parent Signature:_____ Date: