MILESTONE PEDIATRIC THERAPY SERVICES **SPEECH QUESTIONNAIRE**

Patient Name: _____DOB_____Gender M or F

Does your child have an IEP? If yes, please provide a copy to us.

Patient lives with (check one) ___Birth Parents ____Adoptive Parents ___Foster Parents ___One Parent
___Parent and Step-Parent ____Other: _____ Siblings:_____

Is there a language other than English spoken in the home ____YES ____NO
If yes, which one? _____Does the child speak the language:_____
Does the child understand the language:_____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 in school? If yes, What services? _____
_____
How long have you been concerned? _____
Is your child aware/concerned/frustrated? _____

Pregnancy: ___Full-Term ___Premature Birth History: ___Unremarkable ___Complications; please explain:
_____
_____
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 _____
_____
_____
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

Has your child had previous therapy? ___YES ___NO

If yes, when and where? _____

_____

PLEASE PROVIDE A COPY OF LATEST EVALUATIONS/PLANS OF CARE IF CHILD HAS HAD PREVIOUS THERAPY

Has your child had any of the following:

__Adenoidectomy
__Allergies
__Flu
__Breathing difficulty
__Chicken pox
__Colds
__Ear infections
How often?
_____

__Head injury
__Ear tubes
__Encelphalitis
__High fevers
__Measles
__Meningitis
__Mumps
__Scarlet fever

__Tonsillectomy
__Tonsillitis
__Vision problems
__Sinusitis
__Sleeping difficulty
__Thumb/finger sucking
__Seizures

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
__ Sound (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? __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:

Tags or clothing __YES __NO

Loud noises __YES __NO

Walking in sand __YES __NO

Getting their hands dirty __YES __NO

DIfferent textures in food __YES __NO

Transitioning to a new activity __YES __NO

Is your child a picky eater __YES __NO

Other information about your child's communication: _____

_____

_____

_____

Does your child have allergies, if so please list: _____

_____

_____

_____