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PARENT/CAREGIVER QUESTIONNAIRE

GENERAL INFORMATION **Date:** _____

Child's Name: _____ Age: _____

Date of Birth: _____ Sex: _____

Parent/Guardian's Name:_____ Occupation:_____

Level of Education: _____

Parent/Guardian's Name:_____ 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? _____

_____

What are their special interests? _____

_____

What is their primary method of communication? _____

_____

What are their sensory differences or needs? _____

_____

What are their signs of enjoyment? _____

_____

Does your child have specific triggers for meltdowns? _____

_____

What are your child's overt signs of distress? _____

_____

What activities or objects are helpful in holding your child's attention? _____

_____

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? _____

Please describe below important cultural practices, rituals, traditions, or beliefs that you believe are important for us to be aware of prior to initiating a therapeutic relationship: _____

_____

_____

Any other important information you would like to share with us: _____

_____

_____

_____

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 medication? 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	☐ Bladder/bowel trained
☐ Stands alone	☐ Uses 2-word combos
☐ Say 1st 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 face	☐ On body
☐ On mouth/lips	☐ Inside mouth
☐ Toothbrush	☐ Hair brush

When did teeth erupt? _____

Last visit to dentist? _____

Bruxism? Yes No

Thumb sucking? 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? Y/N friends? Y/N strangers? Y/N

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

If so, describe: _____

Can your child follow directions? Yes No

_____ One step directions ____ Two step directions _____ Three step directions

Please rate your child's attention during the following types of activities:

	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: Check all that apply

☐ Reflux	If yes, when?
☐ Constipation	If yes, when?
☐ Loose stools/diarrhea	If yes, when?
☐ Vomiting (not associated with other acute sickness)	If yes, when?

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 within the school 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 some of your child's favorite play activities? _____

_____

What is your child's most frequent problem behavior(s)? _____

_____

Who primarily handles 'discipline' or behavior-change procedures?

_____

How are your child's problem behaviors typically addressed?

_____

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

_____

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

_____

Does your child exhibit any repetitive behaviors? If yes, please describe: _____

_____

Does your child exhibit any restricted routines (i.e., having to adhere to the same way of doing a common activity every time it is performed)? If yes, please describe:_____

_____

Please list any concerns you have about your child's behavior: _____

_____

OTHER COMMENTS: