

Parent Questionnaire for Speech-Language Evaluations

Thank you for taking the time to fill this out. On average this form takes 8 minutes to complete.

Student Name:

Form Completed by:

Date Form Completed:

What do you see as your child's gifts or greatest strengths?

What activities does your child enjoy?

What activities does your family like to do together?

Who does your child live with?

Name	Relation	Age

Does your child spend a significant amount of time in a second household? (babysitter, grandparents)?
___ YES ___ NO

If YES, where does the child spend this time?

Other parent's house

Grandparent's house

Babysitter's house

Other:

Who lives there?

Name	Relation	Age

Does your child speak a language other than English? ___ YES ___ NO

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What is the primary language spoken in the home?

- English Mandarin Other:
 Spanish Vietnamese

Is any other language spoken in the home? ____ YES ____ NO If yes, which language(s)?

- English Mandarin Other:
 Spanish Vietnamese

Speaking

As an estimate, what percentage of the time does the child **speak** each language?

Circle one level for Sections A, B, and C (e.g. 30% 70%)

A. After School		B. Evening/Nights		C. Weekends	
English	Other Language	English	Other Language	English	Other Language
0%	100%	0%	100%	0%	100%
10%	90%	10%	90%	10%	90%
20%	80%	20%	80%	20%	80%
30%	70%	30%	70%	30%	70%
40%	60%	40%	60%	40%	60%
50%	50%	50%	50%	50%	50%
60%	40%	60%	40%	60%	40%
70%	30%	70%	30%	70%	30%
80%	20%	80%	20%	80%	20%
90%	10%	90%	10%	90%	10%
100%	0%	100%	0%	100%	0%

Listening

As an estimate, what percentage of the time does the child **hear** each language?

Circle one level for Sections D, E, and F.

D. After School		E. Evenings/Nights		F. Weekends	
English	Other Language	English	Other Language	English	Other Language
0%	100%	0%	100%	0%	100%
10%	90%	10%	90%	10%	90%
20%	80%	20%	80%	20%	80%
30%	70%	30%	70%	30%	70%
40%	60%	40%	60%	40%	60%
50%	50%	50%	50%	50%	50%
60%	40%	60%	40%	60%	40%
70%	30%	70%	30%	70%	30%
80%	20%	80%	20%	80%	20%
90%	10%	90%	10%	90%	10%
100%	0%	100%	0%	100%	0%

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Sociological

Have there been any significant changes in your child's life over the past three years?
(e.g., death in the family, divorce, new sibling, moves)? ___YES ___NO If yes, please explain:

Medical History

Were there any complications during pregnancy? ___YES ___NO

If yes, please explain:

Has your child had any serious illnesses, accidents, or hospitalizations (i.e., high fever, head injury, surgery)? ___YES ___NO

If yes, please explain:

Has your child ever had therapy or early childhood intervention?

- | | | |
|---|--|---------------------------------|
| <input type="checkbox"/> Speech therapy | <input type="checkbox"/> Early Childhood | <input type="checkbox"/> None |
| <input type="checkbox"/> Occupational therapy | Intervention | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Feeding Therapy | |

If they received services, please tell us more:

Does your child have any medical diagnoses? ___YES ___NO

If yes, please specify.

Has your child had ear infections? ___YES ___NO

If yes, approximately how many ear infections? _____ and at what age? _____

Were Pressure Equalization tubes ("PE tubes") placed in the ears? ___YES ___NO

If yes, date of PE tubes:

Is your child currently taking any medications? ___YES ___NO

If YES, What is the name(s) of the medication(s) and what it's taken for?

Do you have any concerns about your child's physical abilities, such as running, walking, drawing, or using scissors? ___YES ___NO If yes, please explain:

ACADEMIC CONCERNS

Do you have any concerns about your child's academic performance? ___YES ___NO

If yes, please explain:

INTELLIGENCE AND ADAPTIVE BEHAVIOR (SELF-CARE)

How would you rate your child in the following areas? (check the appropriate column)

	Below Others Child's Age	Similar to Others Child's Age	N/A
Remembering things you ask them to do			
Exhibiting organization in accomplishing tasks			
Focusing during activities			
Getting dressed independently			
Taking care of personal items			

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Is there anything else you want to add? ____YES ____NO

If yes, please explain: (Use full sentences)

COMMUNICATION

Do you have concerns about the way your child communicates? ____YES ____NO

If yes, select appropriate concerns. My child:

- is difficult to understand when he speaks
- does not put words together appropriately like others the same age
- has difficulty understanding others
- repeats sounds, words, or phrases (stutters)
- Other: Please explain any other concerns about how your child communicates at home:

Does your child understand what other people say? ____YES ____NO

How much of the child's speech is understood by **family members**?

- Everything (100%)
- Most (75%)
- Some (50%)
- Very Little (25%)
- None (0%)

How much of your child's speech is understood by **strangers or unfamiliar people**?

- Everything (100%)
- Most (75%)
- Some (50%)
- Very Little (25%)
- None (0%)

Does your child stutter, get stuck on words, repeat words, or restart sentences? ____YES ____NO

If yes, how often does this occur?

Did anyone in your family have difficulty communicating when they were young? ____YES ____NO

If yes, who?

Describe your child's behavior at home:

- Easy going
- Well behaved
- Other:
- Active
- Easily Upset

How does your child interact with other children?

- Plays together with other children
- Leads other children in play
- Watches other children play
- Other:
- Avoids playing with other children

Is there anything else you want to add?

Thank you!

Enjoy these forms but we want to give you an update:

Our parent, teacher, and nurse forms have been digitized to be sent at the click of a button. And it gets better, the parent forms can be automatically translated into 16 languages.

Watch this 1 minute video.



www.evalubox.com/speech-referral-form/