MAIA C. KING SPEECH LANGUAGE PATHOLOGIST PLLC

Case Questionnaire

Identifying Information:

1. Parents Name (first and last): _____
2. Your Child's Name (first and last): _____
3. Home address: _____
4. Home Phone: _____
5. Cell Phone:_____
6. Work Phone N/A if you do not wished to be contacted at work _____
7. Email Address: _____
8. Your Child's DOB:_____
9. Referred by:_____
10. Doctor's Name and phone number: (please list all seen by your child) :_____
11. Name of Nursery School/ Day Care; Full Time/ Part Time; schedule: _____ _____
12. Describe a typical day/routine for your child: _____
13. Child lives with (check one): __Birth parent __Foster Parent ___
14. _____Adoptive Parents _____Parent & Step-parent ___One Parent_____ Other _____

FAMILY HISTORY

1. **Is there a family history of (Circle each/one):**
   Speech/Language Difficulties
   Hearing Impairment/Deafness
   Learning Difficulties
   Developmental Difficulties

1. **if you responded "yes" to any of the above, please describe:**

_____
_____
_____
_____

Other Language Exposure

1. Is there a language other than English spoken in the home? ___Y ___N
2. If yes, which language? _____
3. Does the child speak this languag:____Y _____N
4. Does the child understand this language ___Y ____N
5. Which language does the child feel most comfortable with _____ ___NA

6. Birth & Medical History:

Was there anything unusual about your pregnancy or birth (complications, induction, premature labor
etc):_____

_____

_____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING:

Adenoidectomy_____
Allergies (please list)
_____
_____

Breathing Difficulties: _____
Chicken Pox_____
Frequent Colds _____
Frequent Ear Infections: _____
Ear (PE) Tubes:_____
Vision Problems:_____
Seizures:_____

High Fevers _____
Head Injury_____
Sleeping Difficulties
(snore)_____
Tonsillitis _____
Other serious illness:____

- please provide details if checked yes:_____

_____
_____
_____

DATE OF LAST HEARING SCREENING/RESULTS:

_____-____

DATE OF LAST VISION SCREENING/RESULTS:

_____

HOSPITALIZATIONS:_____

_____

MEDICATIONS:_____

_____

DEVELOPMENTAL HISTORY

Please indicate the approximate age your child reached the following milestones:

_____sat alone
_____babbled
_____said first words
_____crawled
_____walked
_____potty trained?

_____put 2 words together _____climbed upstairs
_____ spoke in short sentences

ORAL MOTOR & FEEDING HISTORY:

Has your child experienced any feeding/eating/swallowing difficulties Y/N
If yes please explain _____
Is your child on a bottle? _____
How old was your child when he/she stopped using the bottle?_____
Does your child use a pacifier: _____
How old was your child when he/she stopped using the pacifier:_____
Is your child thumb sucker? How old was your child when he/she stopped thumb sucking? _____
Does your child use open cup/sippy cup/ straw? _____
Do you notice drooling?_____
How old was your child when he/she started eating solids?
_____
Do you notice coughing while eating/ is your child a slow eater?
_____
Is your child a picky eater? _____
Explain_____

SPEECH &LANGUAGE DEVELOPMENT:

1. How does your child prefer to communicate?
_____gestures _____words _____both_____other _____
2. Do you think your child is frustrated?_____ Explain_____
_____
_____
3. Number of words in a typical sentence?
_____
4. How many words do you think your child can understand?
5. How man words do you think your child has in his/her vocabulary?
6. Is your child's speech difficult to understand? _____
Explain:_____
6. What type of speech errors do you notice?
_____
*** Does your child identify objects? ____ actions?_____
ask questions?_____ follow directions? _____

understand what you are saying? _____ respond correctly to Y/N questions _____
Has your child ever been evaluated for speech/pt/ ot? _____
Has your child ever received speech therapy _____
How long and How frequent?_____

Can your child have food for/ during therapy as a reward/ if allergies please specify?

Please provide examples of your child's speech/language and your concerns

_____
_____
_____

FAVORITE ACTIVITIES:

******

Please list your child's favorite activities, hobbies, toys, games, t.v. characters etc

_____
_____
_____