Renee H. Matlock's SPEECH Plus

CONFIDENTIAL QUESTIONNAIRE

The information provided in this questionnaire may be noted in the evaluation report. Please note any information you do not want disclosed.

Please attach copies of pertinent records (School District testing, IEP's, Report Cards, Standardized Test results, Other Evaluation Reports)

Date: _____

CHILD/FAMILY HISTORY

Child's Name _____ Birthdate __/__/__/ Age ___
Last Name First Name Nickname, if any

Sex _____ Grade in School _____

Primary Language(s) of the Home _____ Primary Language of Child _____

Questionnaire completed by: _____

REFERRAL INFORMATION

Referred by _____
Family, Center, Physician, Other Professionals

What do you hope to gain from this evaluation?

_____

_____

What are your main concerns regarding your child's communication skills?

_____

_____

RESPONSIBLE PARTY CONTACT INFORMATION

Responsible Party/Parties & Relationship(s) to Child:

_____

Child lives with:

_____

Responsible Party Contact Information:

_____

Name _____ Phone # (____) _____ (____) _____
Home Work

_____
Street Address City State Zip

Cell/Pager # (____) _____ Fax # (____) _____ Email _____

PARENTS STATUS

Circle one married separated divorced single deceased other

Name	Age	Education	Occupation	Year Married	If divorced, What year?	Lives At home
Mother						
Father						
Stepmother						
Stepfather						

BROTHERS & SISTERS

Name	Age	B=Birth A=Adopted S=Step	Education Achieved	Health Problems	Lives at Home? Yes/No	Sex M/F

Any others living at home? _____

Name(s) Relationship(s)

Any other caregivers?_____

(e.g., daycare providers, regular babysitters, nanny, family, etc.)

Is there a history in the family of speech, language or learning disabilities of any kind, including hyperactivity or Attention Deficit Disorder?_____(If yes, please explain)

_____

_____

_____

Has your child been diagnosed with Autism Spectrum Disorder? _____ Age at time of diagnosis _____ Who made the diagnosis? _____

Has your child previously been diagnosed with any other particular condition that would affect his or her speech, language, or auditory skills? (such as Down Syndrome, PDD, Cerebral Palsy, Hearing Impairment, etc.)

_____

What are your child's favorite activities and games?

_____

_____

DEVELOPMENTAL HISTORY

Prenatal

Please check if your child's mother experienced any of the following health problems during her pregnancy (please comment where appropriate):

__ Excessive nausea/vomiting
__ Heart trouble pneumonia/flu
__ Rh incompatibility
__ Anemia
__ Diabetes
__ Bleeding/spotting
__ Kidney disease
__ Tiredness/fatigue
__ Exposure to smoking (self or others)
__ Exposure to drugs (prescription, over-the counter, or other)
__ Premature contractions
__ High blood pressure
__ Thyroid disease
__ Diarrhea
__ Fever
__ German measles
__ Measles
__ Confined to bed
__ Excessive weight gain
__ Weight gain < 10 lbs.
__ Special diet
__ Toxemia (swelling)
__ Unusual worries
__ Medications other than vitamins
__ Illness/pneumonia/flu
__ Accident
__ Exposure to alcohol

LABOR AND DELIVERY

Length of labor _____ Apgar score: _____

Birth weight: _____ Birth length: _____

Hospitalized in: _____ Regular nursery _____ Special care nursery
Length of stay _____ Regular nursery _____ Special care nursery

Required transfer to another hospital: Yes _____ No _____ If yes, explain: _____

_____

Reason for extended stay: _____

			Comments:
Full Term	Yes _____	No _____	_____
Premature birth	Yes _____	No _____	_____
Pitocin Induction	Yes _____	No _____	_____
Position (breach)	Yes _____	No _____	_____
Suction/Forceps	Yes _____	No _____	_____
Caesarean (reason?)	Yes _____	No _____	_____
Cried immediately	Yes _____	No _____	_____
Blue baby	Yes _____	No _____	_____
Jaundice	Yes _____	No _____	_____
Other complications?	Yes _____	No _____	_____

ADOPTION (*Complete only if appropriate)*

Child's age when adopted: _____Child aware of adoption? Yes _____ No _____

Please tell the circumstance surrounding the adoption and any information about birth parents:

_____

_____

Prior homes: _____

Response to new home? _____

_____

_____

_____

INFANCY/CHILDHOOD

Please describe in detail the **first two years** of your child's life. Was he/she fussy, happy, etc.? If colicky, how long and how severe? Was your child was difficult to calm? Did any outstanding events occur? Was child exposed to any toxins?

_____

_____

_____

_____

List any reactions to immunizations: _____

		Comments
Breastfed	Yes ____ No ____	_____
Toilet trained	Yes ____ No ____	_____
Thumb-sucking/pacifier use	Yes ____ No ____	_____
Extended separations during The first two years	Yes ____ No ____	_____
Specific health problems During this period	Yes ____ No ____	_____

DEVELOPMENTAL MILESTONES

Check all that apply: My child was

_____ alert _____ easily comforted _____ colicky
_____ aware of light/sound _____ difficult to comfort _____ lethargic

Did you find your child's early motor development (e.g., walking, talking, toilet training, etc.) to be:
_____ Early _____ Average _____ Late

Please indicate when your child first did the following:

Sat alone ____ months Said first word(s) ____ months Walked without holding ____ months

Crawled _____ months Used 2-3 word phrases ____ months Used sentences ____ months

Did your child babble and coo? _____

Was your child a quiet baby? _____

HEALTH

Name/Address of Physician _____

_____

How would you describe your child's health during his/her first two years?_____

How would you describe your child's health since age two? _____

When was your child's most recent medical check-up? _____

Describe your child's current general health? _____

Does your child have a history of the following?

	Yes	No	Comments
Allergies			
Asthma			
Autism/PDD/Aspergers			
Bronchitis			
Seizures			
Ear Infections			
Epilepsy			
Fitful sleep			
Gastrointestinal Problems			
Injuries			
Sensory Integration Issues			
Surgeries			
Hospitalizations			

Is your child currently taking any prescribed medication? How much and for what condition?

_____

Is your child following a particular diet?

_____

Has medication been prescribed in the past to help your child's mood or behavior?

_____

Visual Development

Does your child have vision problems? _____ Please describe _____

_____

Has your child ever had an eye exam? Yes _____ No _____ Date of test _____

If yes, what were the results? _____ Doctor: _____

Does your child?

Yes ___ No ___ Wear Glasses?

Yes ___ No___ Appear to be sensitive to light

Yes ___ No___ Explore objects using peripheral vision?

Yes ___ No___ Resist having vision occluded?

Yes ___ No___ Squint or close one eye when looking at things?

Yes___ No___ Appear not to notice things in their environment or focus on minute detail?

Yes___ No___ Have an attraction to spinning objects or vertical or horizontal lines?

Yes___ No___ Get over-excited when confronted with variety of stimuli?

Yes___ No___ Discriminate colors, shapes?

Has your child had any experience with vision training in the past? If so, what, when, and where?

_____

_____

PREVIOUS EVALUATIONS AND TREATMENT

Has your child ever been evaluated for a speech, language, or auditory problem in the past?

Yes _____ No_____ If yes, when? _____

Has your child been evaluated or treated by a physical or occupational therapist?

Yes _____ No_____ If yes, when?_____

Result: _____

Has your child been evaluated by a psychologist or learning consultant?

Yes _____ No_____ If yes, when? _____

Result:

_____

Has your child been evaluated by a neurologist?

Yes _____ No_____ If yes, when? _____

Result: _____

Has your child been evaluated by an ear-nose-throat physician?

Yes _____ No_____ If yes, when? _____

Result: _____

SOCIAL INTERACTION AND BEHAVIOR (*check all that apply*)

Typical for age _____ quiet _____ outgoing ____

_____Likes to point out things to show you

_____Does not play "pretend" or imaginary games well

_____Usually doesn't acknowledge people (waving, saying "hi") when they enter unless prompted

_____Usually doesn't acknowledge people when they leave (waving, saying "bye") unless prompted

_____Is unusually active for his/her age

_____Tends to prefer playing alone

_____Prefers to play with younger children

_____Has a shorter attention span than you expect for his/her age

_____Avoids eye contact

_____Doesn't seem to know *how* to interact with other children (although wants to)

_____Is unusually irritable in noisy or crowded places such as malls, parties, etc.

_____Often repeats phrases heard out of context

_____Doesn't respond to his/her name consistently

_____Has periodic screaming fits (beyond typical tantrums)

_____Short temper

_____Can be violent or unusually physically aggressive (beyond typical childhood outbursts)

Any other behavior or emotional issues? _____

AUDITORY DEVELOPMENT

Does your child have a hearing problem? _____
Please describe _____

Has your child had his/her hearing tested? Yes _____ No _____ Date of test _____

If yes, what were the results? _____

_____

Did your child have any ear problems before the age of 2 (e.g., ear infections, ear aches, draining ears, fluid behind the ears, medications taken for ears, etc.)? _____

Approximately how many ear problems/infections has your child had in his/her life? _____

Did your child have PE tubes? _____ Dates _____

Does your child have a diagnosed hearing loss? _____

Have you or others ever thought your child was deaf? _____

Has your child had any training with sound stimulation, auditory processing training in the past? If so, what, when, and where? _____

Does your child:

Yes___ No___ Hear things before you hear them?

Yes___ No___ Seem overly sensitive to sound?

Yes___ No___ Become frightened by certain sounds, such as certain machinery, toys, voices, or other things? If so, what are the sounds? _____

Yes___ No___ Miss some sounds?

Yes___ No___ Seem confused about the direction of sounds?

Yes___ No___ Like to make loud noises?

Yes___ No___ Become easily distracted?

Yes___ No___ Tend to "tune you out" when there is background noise present, such as a dishwasher or TV?

Yes___ No___ Need to have instructions repeated frequently?

Yes___ No___ Often say, "What"? or "Huh"?

Yes___ No___ Often fail to pay attention when being spoken to?

Yes___ No___ Often need an unusually long amount of time to process verbal information before responding?

Yes___ No___ Often have difficulty remembering what is said?

Yes___ No___ Frequently lose his/her concentration?

Yes___ No___ Have others (i.e., teachers, therapist) who work with child commented on his/her listening skills?

Are you concerned that your child may have Attention Deficit Disorder? (if not already diagnosed)

_____

_____

SPEECH AND LANGUAGE DEVELOPMENT

Is your child talking yet? _____

Describe your child's speech and language and any problems: _____

_____

Does your child have difficulty pronouncing certain sounds? (if so, please list if you can) _____

_____

Does your child mumble often? _____

Does your child seem inhibited by his or her speech difficulty? _____

Does your child often reduce or transpose the number of syllables in a word? (ex: "Indiana" Pronounced as "danna" _____

If school age, does your child write words with the same error pattern exhibited in their speech? (ex: child writes "wabbit" instead of "rabbit" or "fink" instead of "think") _____

What percentage of speech can mother understand?

_____ all _____ most _____ some _____ very little

What percentage of speech can other adults understand?

_____ all _____ most _____ some _____ very little

EXPRESSIVE LANGUAGE

Does your child use a lot of gestures? _____

Does your child seem frustrated by his/her difficulty with talking? _____

Does your child nod his/her head for yes/no questions? _____

Does your child repeat (echo) the question instead of answering it? _____

Does your child seem disinterested in talking? _____

Does your child seem overly interested in one particular thing (such as trains?) _____

Does your child seem to be exceptionally good at learning letters, reading? _____

Does your child seem to be exceptionally good at doing puzzles? _____

Does your child seem to be exceptionally good or interested in computers? _____

Does your child tend to "ramble on" (out of sequence) when retelling events or explaining so that it is difficult to follow (that is unusual for his/her age)? _____

Does your child use an inordinate amount of "uhs" and "ums" in his/her conversational speech?

_____

Does your child use vague language frequently, so that it is difficult to follow at times? (such as "She put the thing on that other place") _____

Does your child tend to confuse positional words, such as "left/right"? _____

Does your child have difficulty speaking in complete sentences with normal grammar? _____

Does your child forget names of familiar things? (May use words such as "whatchamachallit" and get frustrated) _____

Does your child have difficulty elaborating on a topic; yet can answer Y/N questions about it? (such as "Was Jacob at the party?")

_____

Does your child have trouble answering "wh" questions (such as "Who was at the party?")

_____

MOTOR DEVELOPMENT

Hand Dominance: R _____ L _____ Age established _____

Does your child: *Muscle Tone*

Yes___ No___ Have a grasp of a crayon/pencil that is less mature than peers?

Yes___ No___ Seem weaker or stronger than normal? _____

Yes___ No___ Have any diagnosed muscle pathology (e.g., spasticity, flaccidity, rigidity)
Explain _____

_____

Does your child: *Coordination*

Yes___ No___ Have difficulty manipulating small objects easily?

Yes___No___ Seem accident prone?

Yes___No___ Eat in a sloppy manner?

Yes___No___ Have difficulty dressing and/or fastening clothes? Explain_____

Yes___No___ Have a consistent hand dominance? Explain_____

Yes___No___ Neglect one side of the body, or seem unaware of it? Explain_____

Yes___No___ Have trouble riding a tricycle and/or bicycle?

Yes___No___ Have trouble playing on playground equipment?

Sensory – Tactile Sensation

Yes___No___ Object to being touched/cuddled? Explain_____

Yes___No___ React negatively to the feel of new clothes?

Yes___No___ Prefer certain textures of clothing?

Yes___No___ Dislike having hair and/or face washed?

Yes___No___ Dislike having teeth brushed and/or nails clipped? Explain_____

Yes___No___ Avoid certain textures of food?

Yes___No___ Isolate self from other children? Explain_____

Sensory – Vestibular Sensation

Yes___No___ Seem fearful in space (i.e., going up/down stairs) Explain_____

Yes___No___ Appear clumsy, often bumps into things or others, falls down? Explain_____

Yes___No___ Climb well but is cautious of others bumping into him/her? Explain_____

Yes___No___ Spin self? Explain_____

Yes___No___ Walk upstairs always leading with same foot? Explain_____

Sensory – Olfactory Sensation

Yes___No___ Explore the environment with smell? Explain_____

Yes___No___ Discriminate odors poorly?

Yes___No___ React defensively to smell? Explain_____

Sensory – Gustatory Sensation

Yes___No___ Act as though all food tastes the same? Explain_____

Yes___No___ Open to tasting new foods?

Yes___No___ Dislike foods of a certain texture or multiple textures? Explain_____

Yes___No___ Avoid or crave certain temperatures of food? Explain_____

ORAL MOTOR DEVELOPMENT

How would you describe your child's chewing and swallowing? (check all that apply)

_____ Typical for his/her age

_____ Messy for his/her age

_____ Chokes at times more than I would expect

_____ Has a very limited number of foods he/she will eat
(please list favorites_____)

_____ Avoids hard and crunchy foods

_____ Stuffs lots of food into his/her mouth at once

_____ Drools when at rest

_____ Drools when eating

_____ Liquids leak from nose

Does your child resist getting his/her teeth brushed?

_____

Does your child resist getting his/her face washed?

_____

Are you concerned about your child's nutrition as a result of his or her feeding difficulties?

_____

Describe any feeding or nutritional concerns you may have.

_____

EDUCATIONAL HISTORY

Did your child attend preschool? _____Where?_____

What hours/days does your child attend school? _____

Has your child ever repeated a grade?_____ Which grade_____

Has your child ever participated in a special education evaluation?_____ If so, when?_____

Has the school system made an Individual Education Plan (IEP) for your child?_____

Date of last IEP_____ School district_____

Did you decline special education services or evaluations that were offered in the public school for your child? Yes____ No_____

Has your child been given an IQ score?

_____

If so, please describe when, where, by whom & results

_____

Please list the schools that your child has attended, including his/her current school:

School/Location ***Grade***

_____

_____

_____

Has or is your child receiving: (please check appropriate boxes)

	Current	Past	Year/Grade	Frequency	Location
Special Education Classes					
Remedial Classes					
Tutoring/Remedial Help					
Speech/Language Therapy					
Physical/Occupational Therapy					
Counseling/Therapy					

What are your child's current grades in school? _____

SCHOOL ISSUES

If your child is presently attending school, please check off the area in which he or she is experiencing difficulty:

_____ learning the names of letters
_____ printing the letters

_____ spacing the letters and words on the page
_____ remembering the sounds the letters make
_____ putting the letters together to sound out a word
_____ comprehending information they read
_____ following directions from the teacher
_____ spelling
_____ writing spelling words in sentences that are not dull and repetitive
_____ keeping his/her attention on the teacher
_____ getting homework completed independently
_____ gripping the pencil without breaking the pencil tip or getting sore
_____ copying letters or words from the blackboard onto his/her paper
_____ copying anything from a book or paper onto another paper
_____ forgetting assignments/books at school
_____ learning math facts
_____ understanding math word problems
_____ learning and remembering vocabulary for classes such as Social Studies/Science
_____ pronouncing and learning new multi-syllabic words (long words)
_____ remembering what people say
_____ putting things in order (for example the sequence of directions gets mixed up, the order of the day of the week, months of the year, phone number, etc.
_____ misunderstanding what to do on projects or homework assignments
_____ taking tests orally _____ answering fill-in-the blank tests
_____ answering open-ended essay tests

Additional Parent Observations / Comments regarding: Academic Achievement:

_____

_____

_____

BEHAVIOR/CHARACTER

Please describe your child's behaviors that are of concern at home, at school, and/or in the community. What was the age of onset and the age when you became concerned?

_____

_____

_____

Please tell us about your child's behavior and character. What kind of person is he/she?

_____

_____

Strengths *Weaknesses*

_____ _____

_____ _____

Please check any behavior characteristics that apply to your child:

_____ Aggression	_____ Low self –esteem	_____ Short attention span
_____ Unusual fears	_____ Manipulative	_____ Sleep problems
_____ Depression	_____ Nail biting	_____ Frequent crying
_____ Impulsive	_____ Nightmares	_____ Truancy
_____ Noncompliant	_____ Perfectionist	_____ Moodiness
_____ Substance abuse	_____ Tics/nervous gestures	
_____ Poor motivation/apathy		_____ Bedwetting/toileting problems
_____ Hyperactivity/Attention-Deficit Disorder		_____Unkempt personal appearance

For any behavior characteristic that you checked, please explain and provide specific examples. This information assists us in better understanding your child's personality and needs.

_____

_____

_____

Please check which areas are of concern to you:

_____ Attention	_____ Focusing
_____ Following Directions	_____ Understanding what is being said
_____ Behavior	_____ Speech
_____ Language	_____ Tantrums
_____ Motor Skills	_____ Reading & Spelling
_____ Learning	_____ Social Skills
_____ Transitions and Flexibility	_____ Sleep Patters
_____ Food Habits	_____ Other (*describe)*_____

Please check areas you would like to see improved:

_____ Listening	_____ Learning
_____ Attention	_____ Speaking
_____ Behavior	_____ Critical Thinking
_____ Reading & Spelling	_____ Organization
_____ Social & Behavioral Skills	_____ Memory
_____ Motor Skills	

Describe your child's typical day: _____

_____

_____

Describe your child's play, interests, activities: _____

_____

_____

Does your child prefer to play alone or with others?_____

Is there any additional information that may help us better understand your child? _____

_____

_____