# FUNctionabilities

## Speech Therapy Pre-Exam Questionnaire

*In order to evaluate your child's condition fully, please be as accurate as possible. Thank you.*

Child's Name: _____ Date of Birth:_____

When was hearing last screened/tested? Date: _____ Results: _____

Primary Language Spoken in the Home: _____

### Previous Speech Therapy History

Has your child received speech therapy services in the past? ☐ Yes (Explain below) ☐ No

### Family History

Please list names, ages, and education level of anyone living in the home:

Is there history of speech and/or language problems in the immediate or extended family? ☐ Yes (Explain below) ☐ No

### Birth History

Were there any difficulties/complications/illnesses/accidents during pregnancy or birth? ☐ Yes (Explain below) ☐ No

Use of alcohol, tobacco, or medications during pregnancy: ☐ Yes (Explain below) ☐ No

Full term? ☐ Yes ☐ No If no, how many weeks? _____ Type of birth: ☐ Vaginal ☐ Caesarean Birth weight _____
Condition of child at birth:

### Medical History

Does your child have allergies? ☐ Yes (Please list below) ☐ No

Current medications:

Any serious or recurring illnesses? ☐ Yes (Explain below) ☐ No

List all hospitalizations with dates:

What is your child's current general health:

Are there concerns with your child's: vision ☐ Yes (Explain below) ☐ No Dental ☐ Yes (Explain below) ☐ No

Please list any other significant health concerns:

### School History

Child's current school and grade level:
Child's general educational performance:
Does your child receive specialized services at school? ☐ Yes (Explain below) ☐ No
How does your child's teacher describe his or her performance in school?

### Developmental History

Age of your child when the following developmental milestones were met? *(If you don't know ages, indicate if on time or delayed):*

sat unassisted _____ crawled _____ walked _____ toilet trained _____ dressed self _____ fed self _____
used gestures _____ babbled _____ single words _____ combined words _____ sentences _____

Describe your child's sleep patterns:

## Present Speech and Language Concerns

*Articulation:*

Do you have concerns with how your child pronounces words? ☐ Yes (Explain below) ☐ No

How much do you understand of what your child says? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-90% ☐ 90-100%
How much do others understand of what your child says? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-90% ☐ 90-100%
Can your child imitate words? ☐ Yes (Explain below) ☐ No

*Language:*

Does your child communicate verbally? ☐ Yes (Explain below) ☐ No
If yes, do they use: ☐ 1 word phrases ☐ 2-3 word phrases ☐ 4+ word phrases
If no, what does your child use to communicate?

Does your child:
Follow directions? ☐ Yes ☐ No Attend to books read to him? ☐ Yes ☐ No Point to named pictures in book? ☐ Yes ☐ No
Name pictures in books? ☐ Yes ☐ No Answer yes/no questions? ☐ Yes ☐ No Answer who/what/when/where/why questions? ☐ Yes ☐ No Understand basic concepts? Colors: ☐ Yes ☐ No Letters: ☐ Yes ☐ No Numbers: ☐ Yes ☐ No
Shapes: ☐ Yes ☐ No Body Parts: ☐ Yes ☐ No

*Social:*

Does your child:
Greet others? ☐ Yes ☐ No Speak to other children? ☐ Yes ☐ No Speak to adults? ☐ Yes ☐ No
Make appropriate eye contact when listening and speaking? ☐ Yes ☐ No Play with other children? ☐ Yes ☐ No
Do you have concerns with how your child interacts with peers and adults? ☐ Yes (Explain below) ☐ No

*Voice:*

Can your child speak in a: Normal volume ☐ Yes ☐ No Whisper ☐ Yes ☐ No Shout ☐ Yes ☐ No
Does your child's voice have a "hoarse" vocal quality at any time? ☐ Yes ☐ No

*Fluency:*

Does your child ever have difficulty communicating wants/needs due to stuttering? (Repetition of sounds/words, i.e. "I-I-I want to play" or "I w-w-want to play") ☐ Yes (Explain below) ☐ No

*Augmentative Communication:*

Does your child use an augmentative or alternative communication device (AAC)? ☐ Yes (Explain below) ☐ No
Please list type of device, level of program, and how often it is used:

*Other:*

Please list your child's favorite activities:
What motivates your child?
Please describe your child's strengths:
How does your child handle frustration?
What discipline methods work best for your child?

*Please provide a copy of your child's most recent IEP and/or previous speech evaluations. This helps assist with gathering all information necessary to establish therapy goals and align goals with those targeted in school.

Patient Name: _____ Parent/Guardian Signature: _____ Date: _____