pickletree
PEDIATRIC THERAPY
SPEECH · LANGUAGE · LITERACY

Evaluation Questionnaire

Date: _____

In order to provide you with the best service and to keep time spent in evaluation to a minimum, please provide the following information. Not all information will apply to you. Also, please provide any additional copies of tests administered elsewhere or other information that you feel might be relevant. Thank you.

General Information:

Client Name: _____ Birthdate: _____ Age: _____

Legal Guardian(s) Name(s):_____

Address: _____ Day Phone: _____

Client's Occupations(s): _____

Have other siblings or family members experienced speech/language difficulties? If so, whom:

_____

What language(s) is/are spoken in the home?_____

In case of emergency, notify: _____

Physician: _____ Dentist: _____

Orthodontist: _____ Other Therapist: _____

Other Doctor: _____ Referred by: _____

Statement of Problem:

Describe your speech/language/auditory/orthodontic problem: _____

_____

When was the problem first noticed: _____

What strategies have been used at home that seem to help: _____

_____

What professional services have you received: _____

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Speech, Language and Hearing History:

Did you receive speech-language therapy as a child?_____If yes, for what and how long?

_____

Has speech/language been tested in the last 6 months? By whom?_____

Has hearing been tested in the past year? By whom?_____

Has vision been tested in the past year? By whom?_____

Social Behavior:

Is it difficult or uncomfortable for you to:

Make eye contact _____

Respond on topic _____

Interrupt appropriately _____

Stay on topic _____

Tell you the names of things _____

Tell you how things are used _____

Describe things and actions _____

Ask for information _____

Give information _____

Make requests _____

Apologize _____

Protest _____

Show humor _____

Solve problems verbally _____

Greet people _____

Have sensitivity to touch _____

Have sensitivity to sound _____

Other _____

Medical History:

Age Severity

Tonsillitis: _____

Tonsillectomy: _____

Adenoidectomy: _____

Lingual Frenectomy: _____

Middle Ear Infections: _____

Earaches: _____

Ear Surgery: _____

Hearing Loss: _____

High Fevers: _____

Measles: _____

Mumps: _____

Pneumonia: _____

Frequent Colds: _____

Upper Respiratory Infections: _____

Snoring: _____

Allergies: _____

Asthma: _____

Sinus Problems: _____

Headaches: _____

Seizures: _____

Head Injury: _____

Loss of Consciousness: _____

GERD (Acid Reflux): _____

Visual difficulty: _____

Are you currently under a physician's care? For: _____

Are you taking any medications? _____

Other medical conditions not mentioned: _____

Is there smoking in the home? _____

Is general health good? _____

Dental History:

Have you ever sucked thumb/fingers: _____ Until what age: _____

Did you use a pacifier: _____ Until what age: _____

Were baby teeth normal? Were baby teeth lost at normal ages? Were baby teeth lost to accident or injury? _____

Do you have cavities or periodontal disease: _____

How often do you brush your teeth? _____ Flossing per week? _____

Does anyone in your family have similar dental conditions: _____

Do you clench or grind teeth at night: _____ Day: _____

Do you have any pain or clicking upon closing the mouth: _____

opening widely: _____ chewing: _____ Any other facial pain: _____

Do you have difficulty chewing, eating, and/or swallowing food: _____

Do you often have headaches: _____ Any severe facial injuries: _____

Have permanent teeth been injured/chipped/lost: _____ Which teeth and when: _____ Extra teeth: _____

If you have seen an orthodontist, what has been done so far? _____

Any orthodontic appliances in currently in place? _____

Are adjustments still being made? _____ When will appliance come off? _____

What does the orthodontist plan to do in the future? When? _____

If orthodontic treatment is completed, how long were braces worn? _____

How long ago were braces removed? _____ What kind of retainer is worn? _____

Has occlusion gotten better, worse, or stayed the same during the last 6-12 months? _____

What other family members had orthodontic treatment? _____

Have other family members had oromyofunctional treatment? _____

Associated Oral Behaviors:

Do you breath through mouth, nose, or both? _____

Is mouth open or closed while watching TV, riding in car, or sleeping? _____

Do you bite your fingernails? _____ Do you chew on pencils, shirt, etc? _____

Do you lick your lips excessively? _____ Are lips chapped much of the time? _____

Do you prop your chin on palm or fist? _____ Do you chew gum excessively? _____

Educational Information:

School: _____Grade: _____

Address: _____ Teacher's Name: _____

Did you excel in any subjects/areas? _____

Did you struggle in any subjects/areas?_____

Did you read at grade level? _____ Do you enjoy reading? _____

Did you spell at grade level? _____ Do you enjoy writing? _____

How did you feel about school and your teachers? _____

_____

Have you been in any special programs (Speech, Language, Reading, Special Ed., etc.):

_____

If so, Teacher's/SLP's Name(s): _____

Other Factors/Family History:

If you were to indicate factors that may be related to your problem, which ones would you include? Circle as many factors as you think are important.

Anxiety/Nervousness
Autism
Behavior Problem
Birth Injury/Trauma
Brain Injury
Cerebral Palsy
Difficulties with Attention
Emotional
Environmental Problems
Epilepsy
Family Trauma
Feeding Problems
Genetics/Heredity
Hearing Loss
Inconsistency in Parenting
Lack of Playmates
Mental Retardation
Neglect by Father
Neglect by Mother
Overprotection by Father
Overprotection by Mother
Recent Move
Sensory Integration
Shyness
Sibling Rivalry
Slow Development
Stubbornness
Visual Disturbances

Other: _____

Questions & Additional Information:

Are there specific questions you would like answered about your treatment?

Is there anything else about yourself, and or your family that I should know that might help me provide better service?

I know this is exhaustive!
Thank you for taking the time to fill out this questionnaire.