CENTER FOR SPEECH & LANGUAGE, INC.

RHONDA H. HEMPHILL, M.S., C.C.C.
AND ASSOCIATES

INITIAL EVALUATION QUESTIONNAIRE (CHILDREN)

Today's Date_____

Name of Child _____ Date of Birth_____

Street Address _____

City _____ Zip _____ Home Phone _____

Mother's Name _____ Date of Birth _____

Address _____ Cell Phone _____

Occupation _____ E-mail address _____

Employer _____ Work Phone _____

Education _____

Father's Name _____ Date of Birth _____

Address _____ Cell Phone _____

Occupation _____ E-mail address _____

Employer _____ Work Phone _____

Education _____

Person responsible for payment _____

Child's doctor/pediatrician & address _____

_____

Child's dentist _____

Who referred you to this Center ? _____

What is their relationship to you (i.e., teacher, friend, family)_____

Other Children in family:

Name	Date of Birth	Age	School	Grade	Speech/lang. Problem?

5020 Goddard Avenue • Orlando, Florida 32804 • 407-299-1533 • Fax 407-295-5965
www.CenterForSpeechOrlando.com

Describe the problem for which testing is being requested_____

_____

Possible cause_____

When did you first notice a problem with your child's speech or language?_____

_____

How has the problem changed over time? _____

Does your child think he/she has a problem? _____

_____

What have you done at home to help your child? _____

_____

Has it worked? _____

Has your child ever had speech or language testing? _____

Where? _____ When? _____

What were the results? _____

Does anyone else in the family have a speech, language or hearing problem? If so, please describe. _____

What information do you hope to get from this evaluation? _____

_____

BIRTH HISTORY

Was child adopted? _____ At what age? _____

Health of mother during pregnancy_____

Illnesses, accidents, drugs or other unusual factors related to pregnancy _____

_____

Was the child full term? _____ If no, how many weeks early? _____

Delivered by Caesarean section? _____ Were forceps used? _____ Breech? _____

Condition of child after birth _____

DEVELOPMENTAL HISTORY

Give approximate age when child:

First crawled _____ First sat without support _____ Walked alone _____

Dressed Self _____ Fed self _____ Ate solids _____

Gained control of bladder _____Gained control of bowels_____

First used words _____ First combined words_____

Please explain if child had difficulty with any of the above events _____

_____

Did child have any sucking, swallowing or other feeding problems? _____

Please explain _____

Which hand does the child prefer? _____

How would you describe your child's personality? _____

_____

Is child's general coordination good? _____

HEALTH HISTORY

Has your child had any of the following? Check and give dates.

	Date(s)		Date(s)
_____	Autism _____	_____	Ear Infections _____
_____	Chickenpox _____	_____	Tubes _____
_____	Scarlet Fever_____	_____	Suspected Hearing Loss _____
_____	Meningitis _____	_____	Dental Problems _____
_____	High Fevers _____		appliances/braces/retainer/cavities
_____	Seizures _____		or other _____
_____	Allergies _____	_____	Vision Problems _____
_____	Accidents _____		glasses for near/far sightedness
_____	ADD/ADHD _____		tracking/convergence _____
_____	Operations _____	_____	Frequent colds _____
_____	Asthma _____		and sore throats
_____	Measles/Mumps _____	_____	Other _____

If you checked any of the above, please explain: _____

_____

Has your child been hospitalized since birth? _____ For what reason? _____

_____ Please list any medications the child

takes currently _____

Has your child ever been seen by a doctor other than his/her pediatrician (ex.,

Neurologist, Psychiatrist, ENT, etc.)? _____

For what problem? _____

Has your child ever been seen by a physical or occupational therapist? _____

What were the results? _____

EDUCATION

Name & address of current school _____ Grade _____
Names, places and dates of attendance of previous schools (including preschool)

Name	City	Dates/Grades
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child currently attend day care? _____ For how long each day? _____

Has your child attended day care previously? _____

Does your child like school? _____

What are his/her easiest subjects? _____

What are his/her most difficult subjects? _____

Has your child ever failed or skipped a grade? _____

Has he/she ever had an intelligence test? _____

Does he/she now or has he/she in the past attended any special classes (speech therapy, reading, learning disabilities, gifted, etc.)? _____ Specify which and dates _____
_____

What grades does your child receive? _____

SOCIAL HISTORY

Does your child live with both parents?_____

Has there been any changes in the family (death, divorce, severe or prolonged illness, frequent moves)? Describe _____

_____

What language(s) other than English is spoken in the home? _____

Does your child play with other children in the neighborhood? _____

Does he/she prefer to play with older or younger children? _____

Does he/she prefer to play alone? _____

Does he/she play well with brothers and/or sisters? _____

What play activities does your child prefer? _____

What activities do you do with your child? _____

Has your child shown behaviors such as excessive crying, shyness, daydreaming, fighting, temper tantrums, lying, etc.? Please describe: _____

_____

What discipline problems do you have with your child? _____

_____

How is the child disciplined (spanking, punishment, etc.)? _____

_____

Please list names and addresses of doctors, schools, agencies and/or other professionals to whom you would like the report sent. (If you don't have exact address, street name would be sufficient).

_____

_____

_____