Stepping Stones Therapy
for kids

OCCUPATIONAL, PHYSICAL & SPEECH THERAPY

INITIAL SPEECH THERAPY EVALUATION
PATIENT INFORMATION

Please fill out this questionnaire as completely as possible. Additional written comments are welcome. If you have questions,contact Stepping Stones Therapy for Kids, and your question will be directed to the appropriate therapist. If your child has participated in a previous speech therapy evaluation through another agency or the school, please provide us with a copy of any previous records (i.e., evaluation report, school IEP, progress report). Thank you so much!

BACKGROUND:

Child's Name: _____ Today's Date: _____
Child's Date of Birth: _____ Age: _____ Gender: M or F
Pediatrician: _____

FAMILY INFORMATION:

Parent/Guardian's Name: _____
Phone: _____ Email: _____
Occupation: _____
Parent/Guardian's Name: _____
Occupation: _____
Phone: _____ Email: _____
Number of Children in Family and Ages: _____
Are there any family members or relatives who have had speech, language, voice, hearing, reading, or writing difficulties? (If yes, please provide further explanation.) _____
_____
Who does the child live with at home? _____

LANGUAGE INFORMATION:

What is your child's ethnicity? _____ What is your child's primary language? _____
Is another language spoken in your home? _____ If yes, what other language is spoken? _____
Does your child speak a second language? _____ If yes, what other language is spoken? _____
What percentage of the time does your child communicate in English? _____

AREA OF CONCERN:

Reason for Seeking Evaluation and/or Therapy: _____
_____
Has your child participated in a previous evaluation and/or therapy? YES or NO (If yes, please list the type of help,

dates of service, and the name of the professional/agency involved.) _____

_____

When did you first notice your child's difficulties, and how were they apparent to you? _____

_____

DEVELOPMENTAL HISTORY:

Prenatal History

Mother's Age at Birth: _____ Father's Age at Birth: _____ Did the mother take any medication(s) during pregnancy? _____If yes, please list the medication(s): _____

Were there complications during pregnancy (i.e., illness, Rh negative, German measles)? _____ If yes, please describe: _____ Was the baby full term? _____

If the baby was premature, please give: Weeks: _____ Weight: _____Time in NICU? _____

What was the length of labor? _____ Induced? _____ Cesarean? _____ APGAR Score? _____

Medication during delivery? _____ Were forceps used? _____ Time on ventilator/oxygen?_____

Were there complications such as: Difficulty breathing? _____ Difficulty sucking? _____ Tube feeding? _____

Difficulty feeding? _____ Seizures? _____ Birth defect? _____ Incubation? _____ Transfusions? _____

Extended hospital stay? _____ Jaundice? _____ Rubella? _____ Herpes/Syphilis? _____ Sepsis? _____

Other (Please specify)? _____

Was your child breastfed? _____ If yes, how many weeks/months? _____ Did your child have any difficulty with breast feeding or bottle feeding?_____ If yes, please explain: _____

Has your child/baby been checked for lip and/or tongue ties:_____

Additional Comments: _____

Infancy/Toddler History

Please give the approximate age of development as closely as possible: Rolled over? _____ Crawled? _____

Sat alone? _____ Walked? _____ Talked (simple words)? _____ Talked (sentences)? _____

Please check the behaviors which best describe your child as an infant:

Cried a lot, demonstrated fussy behavior and irritability? ____ Liked being held?____ Tense when held?____

Demonstrated good, non-demanding behavior?____ Resisted being held?____ Floppy when held? ____

Demonstrated alertness?____ Demonstrated excessive drooling?____ Demonstrated good sleep patterns?____

Demonstrated quiet or passive behavior? ____ Demonstrated high activity level? ____ Demonstrated good sleep patterns? ____ Demonstrated irregular sleep patterns? ____ Other (Please specify)?_____

How does your child get around his/her environment (i.e., crawling, walking, wheelchair)? _____

Does your child use any type of adaptive equipment? _____

Do you have any feeding concerns: _____

Medical History

Has your child had any of the following? If yes, please give dates: Meningitis? _____ Seizures? _____

High temperatures?_____ Ear infections? _____ Allergies (i.e., latex, food, other)? _____

Physical injuries? (Describe and date.) _____

Surgeries and/or medical procedures?(Describe and date.) _____

Hospitalizations? (Describe and date.) _____

Medical diagnosis(es) (i.e., diabetes, epilepsy, heart trouble, autism, ADHD)? _____

Has your child participated in a hearing test? _____ Results? _____

Has your child participated in a vision test? _____ Results? _____

Does your child wear cochlear implants or hearing aids? _____ Does your child wear glasses or contacts? _____
Past Medication(s): _____
Current Medication(s): _____
Other Medical Information: _____
Any Emergency Precautions (i.e., seizure risk, EpiPen): _____

Educational History

Name of School: _____ Teacher: _____
Grade: _____ Does your child attend full time? YES or NO If not, how many days/hours per week? _____
Please list any other school(s) or daycare that your child attends, as well as how often: _____
Does your child receive services for school? _____ If yes, please explain: _____
Please describe your child's: Relationship with Teacher: _____
Relationship with Classmates: _____
Areas of Academic Difficulty: _____
Areas of Most Success and/or Enjoyment: _____
Does your child require any adaptions in the classroom? (Describe.) _____
*****If your child has participated in a speech therapy evaluation through the school district, please bring a copy of the most recent evaluation report and IEP paperwork so that we can best serve your child. Additionally, if you would like for the therapist to communicate with the school therapist, please request to complete a permission form.

Language Development History

At what age did the following occur:

Responded to own name? _____
Followed simple directions? _____
Recognized names of familiar objects?_____
Pointed to eyes, nose, and mouth when named? _____
Babbled? _____
Said first word? _____
Had vocabulary of 10 words? _____
Combined 2 words? _____
Talked in short sentences? _____
Said full name? _____
Verbally related events and/or experiences? _____

Currently:

Does your child follow directions correctly? YES/NO (If no, please explain.) _____
_____
Does your child respond to questions appropriately? YES/NO (If no, please explain.) _____
_____
Do you need to use gestures? YES/NO (If yes, please explain.) _____
_____
Do you need to use repetitions? YES/NO (If yes, please explain.) _____
_____
Do you need to speak in short sentences? YES/NO (If yes, please explain.) _____
_____
How does your child communicate his/her wants and needs? _____
_____

Speech Development History

How much of your child's speech do you understand?

10% 25% 50% 75% 100%

How much of your child's speech do unfamiliar listeners (i.e., acquaintances, strangers) understand?

10% 25% 50% 75% 100%

Does a parent need to interpret for others? YES/NO (If yes, please explain.) _____

_____

CURRENT SPEECH AND LANGUAGE FUNCTIONING:

Are you concerned with your child's ability to understand language (i.e., follow directions, understand questions, identify items by pointing)? YES/NO (If yes, please explain.) _____

_____

Are you concerned with your child's ability to express language (i.e., name objects, answer questions, speak in complete and grammatically-correct sentences)? YES/NO (If yes, please explain.) _____

_____

Are you concerned with your child's ability to use language appropriately (i.e., greet others, make requests, engage in conversation) in social situations? YES/NO (If yes, please explain.) _____

_____

Are you concerned with your child's ability to produce certain speech sounds? YES/NO (If yes, please state the sounds.)

_____

Does your child grope (demonstrate oral movements that do not match the movement that you would typically see in order to produce certain sounds) for words or use the wrong word? YES/NO (If yes, please explain.) _____

_____

Are you concerned with your child's voice (i.e., harsh quality, breathy quality, raspy quality, nasal quality)? YES/NO (If yes, please explain.) _____

_____

Are you concerned with your child's ability to speak fluently without stuttering (i.e., repeating sounds, repeating whole words, repeating whole phrases)? YES/NO (If yes, please explain.)_____

_____

Does your child seem to have adequate hearing? YES/NO (If no, please explain.) _____

_____

Does your child seem to have adequate vision? YES/NO (If no, please explain.) _____

_____

Are you interested in any other types of evaluation for your child (i.e., psychological, audiological, occupational therapy, physical therapy)? YES/NO (If yes, please explain.)_____

_____

What kind of information and strategies would best help you to continue to support your child's communication skills at home? _____

_____

_____

_____

_____

Is there any other information that you would like to share? _____