Speech-Language/Feeding/Hearing Intake Questionnaire

- **If your child has already been given a speech-language/feeding/hearing or other diagnosis by a professional, please list below:**

  Diagnoses/Date/ Provider _____

Please put a check mark by any item that resembles your child.

1. Hearing

____ Has had a hearing test. If so, please indicate date and provider_____
____ Has *never* had a hearing test
____ Responds to sound all the time
____ Responds to sound some of the time
____ Never responds to sound
____ Uses hearing aid or auditory trainer
____ Has cochlear implant; date implanted/provider_____

2. Speech/Voice/Verbal articulation:

____ Has difficulty making speech sounds
____ Has difficulty making self understood to me and/or our family
I understand my child _____% of the time
____ Has difficulty making self understood to others (school, outside community)
Others understand my child _____% of the time.
____ Prolongs or repeats sounds or syllables before initiating speech frequently (i.e. stutters)
____ has difficulty speaking loud enough for others to understand

3. If child communicates verbally, please indicate milestones and approximately when these occurred:

____ Cooing ____ months/years
____ Babbling ____ months/years
____ Responds to name ____ months/years
____ Imitates sounds ____ months/years
____ First Word ____ months/years
____ Phrases ____ months/years
____ Sentences ____ months/years

4. Language/Augmentative Alternative Communication

____Communicates with signs or gestures
____Communicates with pictures or a high-tech speech device
____Uses single signs/words/buttons/gestures
____Combines signs/words/buttons/gestures
____Uses correct word order
____ Puts words together, but not always in the right order
____ Is frustrated by difficulty communicating
____ Follows simple commands
____Appears to understand language like other children of same age
____ Identifies pictures/photos on request

5. Feeding/Swallowing/Nutrition

____Has had a swallow study (results if known) _____
____Eats orally
____Eats by tube
____Coughs/chokes when eating/drinking
____spits up or vomits during or after eating/drinking
____Exhibits frequent drooling (past 24 months of age)
____Was/is treated for reflux with (medication name if known) _____
____Seems underweight

____Is frequently constipated
____Eats a varied diet (20+ foods)
____Picky eater, or has extreme food preferences; i.e. limited repertoire of foods, resistive to trying new foods*
____Dislikes or complains about tooth-brushing; taste of toothpaste or mouthwash*
____Prefers bland foods; avoids foods with intense flavors (spicy, sour)*

6. Respiratory Status/Postural Support:

____Has or has had a tracheostomy tube. Date received _____
____Uses a Passy-Muir speaking valve. How long worn per day_____
____Uses a ventilator to breathe
____Breathes mostly by mouth
____Sits independently
____Needs a high chair, booster or other type of supportive chair to eat
____Fatigues easily

7. Nasopharyngeal and Oral Anatomy history

____Has had tonsils removed. Date/provider _____
____Has had adenoids removed. Date/provider _____
____Has had tongue-tie or lip release. Date/provider _____
____Has history of ear infections. How many/when_____
____Has had PE (ear) tubes placed. Date/provider_____
____Has clefting of lip or palate

8. Social/Emotional/Play*

____ engages in unsafe, fast play
____ difficulty accepting changes in routine
____ gets frustrated easily
____ difficulty making needs known appropriately
____ quickly changing moods
____ prefers playing alone with objects or toys rather than people
____ poor conversation skills
____ poor eye contact
____ does not seek out connections with familiar people
____ wanders aimlessly (over 15 months)
____ excessive irritability
____ fussiness or colic as an infant
____ can't calm or soothe self
____ can't go from sleeping to awake without distress
____ requires excessive help from caregiver to fall asleep

*Based on: http://www.sensory-processing-disorder.com/sensory-processing-disorder-checklist.html

Below, please feel free to share any other information about your concerns or comments that you feel will help us to evaluate your child: