J. Z. MANN PEDIATRIC THERAPY, INC. *ADDENDUM TO PARENT QUESTIONNAIRE (04-2013)*

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

SPEECH & LANGUAGE (SLP/ST) QUESTIONS:

For Speech and Language evaluations the child will need to perform table top tasks such as pointing to pictures, following directions, naming pictures and objects, etc. These tasks need to be done in a standardized manner so that your child's performance can be compared to how a child his/her age would usually perform. You can help your child get ready by having him/her sit at a table, point to pictures, and name pictures while looking at books with you. Doing puzzles and following directions, while at a table top, will help prepare your child for testing. You may contact us if you have concerns or further questions about testing.

Please list any concerns regarding the child's ability to talk/understand what is being said to him/her:_____

_____

How well is child understood by:	Excellent	Good	Fair	Poor	Unintelligible
Parents					
Brothers/Sisters					
Aunts, Uncles, or Grandparents					
Playmates					
Strangers					

How often does child use speech:

□ Frequently □ Occasionally □ Never

Does child ever use gestures and/or pointing to things rather than speech? □ Y □ N

If yes, please explain: _____

_____

Do you think child hears adequately? □ Y □ N

Date of last hearing test: _____

Does child currently have tubes in the ears? □ Y □ N

Do you have concerns about child's hearing? □ Y □ N

If child uses a pacifier, how many hours a day is it in the mouth? _____

Please check all statements which apply:

Statement	Yes	*Statement*	Yes
Has not yet started to talk		Does not seem to hear or understand when I talk to him/her	
Does not say words or sentences correctly		Speaks too fast	
Hesitates or repeats sound and words excessively		Seems to have a hearing loss	
Started talking, then stopped		Points, whines and/or cries	
Has more than normal temper tantrums		Voice sounds "Hoarse"	
Voice sounds "Nasal"		Voice sounds "Too High Pitched"	
Voice sounds "Too Low Pitched"		Voice sounds "Too Loud"	
Voice sounds "Too Soft"			

For any "problems" noted in the chart above, please advise when problem was noticed and what has been done about it:

_____

_____

_____

(Please continue on reverse side)

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CHILD'S NAME: _____ **DATE OF BIRTH:** _____

Has child had any of the following?	Yes	No	Dates
Trach/G-tube			
Mouth / Dental Prostheses			
Hearing Aid(s); Unilateral/bilateral			
P.E Tube(s); Unilateral/bilateral			
Cochlear Implant			
Cleft Palate Repair			
Removal of Tonsils / Adenoids / Both			
Ankyloglossia Surgery			

How does child communicate most often?

□ Complete Sentences □ 2-3 Word Phrases □ Single Words □ Pointing & Crying □ Sounds

Does child mispronounce words? □ Y □ N

Does child ask/answer who/what/when/where/why questions? □ Y □ N

Does child repeat words correctly? □ Y □ N

Does child use grammatically correct sentences? □ Y □ N

Does child stutter? □ Y □ N (*If yes, please complete separate "Stuttering Questionnaire".)*

Does child respond consistently to you and/or others? □ Y □ N

Does child understand directions? □ Y □ N

Does child know any sign language? □ Y □ N; *If yes, what is known?* _____

_____

Is child reading yet? □ Y □ N; *If yes, any problems noted?* _____

_____

FAMILY CONCERNS/GOALS:

Please list YOUR ST concerns:

_____

_____

Please list YOUR ST goals for the child for the next SIX months:

_____

_____