J. Z. MANN PEDIATRIC THERAPY, INC. *ADDENDUM TO PARENT QUESTIONNAIRE*

CHILD'S NAME:_____ DATE OF BIRTH: _____

SPEECH & LANGUAGE (SLP/ST) QUESTIONS:

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

How does your child prefer to communicate? Sounds/Crying _____ Gestures/Pointing ____ Words ____
Phrases_____ Complete Sentences_____

Does your child mispronounce speech sounds in words? _____ If yes, please list the sounds that are mispronounced:
_____

Do you think child hears adequately? Y ___ N ___ **Date of last hearing test:** _____

Does your child:

	Yes	No	N/A		Yes	No	N/A
Coo, babble, vocal play	☐	☐	☐	Retrieve/point to objects	☐	☐	☐
Play peek-a-boo, patty cake, etc.	☐	☐	☐	Respond appropriately to yes/no questions	☐	☐	☐
Engage in independent play (parallel play)	☐	☐	☐	Respond appropriately to WH (who, what, where, etc.) questions	☐	☐	☐
Engage in pretend play (imaginative)	☐	☐	☐	Ask questions	☐	☐	☐
Engage in cooperative play (games, shared play)	☐	☐	☐	Understand when you are talking to him/her	☐	☐	☐
Repeat sounds/words/phrases	☐	☐	☐	Understand and follow directions	☐	☐	☐
Try to get you to notice interesting objects	☐	☐	☐	Use grammatically correct sentences	☐	☐	☐
Look at objects that you point to across the room.	☐	☐	☐	Show frustration with his/her communication difficulty	☐	☐	☐

Please check all statements which apply:

	Yes		Yes
Frequent Ear Infections	☐	Trach/G-Tube	☐
Ear (PE) Tubes	☐	Mouth/Dental Prostheses	☐
Removal of Tonsils	☐	Uses Pacifier	☐
Removal of Adenoids	☐	Thumb/Finger Sucking	☐
Tongue or Lip Tie Surgery	☐	Allergies/Breathing Difficulties	☐
Cleft Palate Repair	☐	Voice Sounds Nasal or Hoarse	☐
Hearing Aid(s)	☐	Voice Sounds Low or High Pitch	☐
Cochlear Implant	☐	Voice Sounds Too Soft or Loud	☐

J. Z. MANN PEDIATRIC THERAPY, INC. *ADDENDUM TO PARENT QUESTIONNAIRE*

CHILD'S NAME:_____ DATE OF BIRTH: _____

ADDITIONAL INFORMATION:

How long does your child attend to: TV_____ Listening to a story _____ Occupy self with toys _____

Can your child sit at a table and complete a task (color, complete a puzzle, look at a book) ____ If so, for how long? ____

Do you have concerns with your child's reading or academic performance (if applicable)? □ **Y** □ **N** *If yes, please explain*:__

_____

What are your child's strengths in school? _____

What are your child's weaknesses in school? _____

Has any other speech/language pathologist seen your child? □ **Y** □ **N** Who and when? _____

What were the conclusions or suggestions? _____

FAMILY CONCERNS/GOALS:

Please list additional concerns regarding your child's communication skills: _____

_____

_____

_____

Please list your goals for your child for the next 6 months: _____

_____

_____

_____

Please tell us anything else that may help us to better understand your child: _____

_____

_____

_____

_____	_____	_____	_____
Signature	Printed Name	Relationship to Patient	Date

Revised 3/1/18