KINETIC KIDS, INCORPORATED
Occupational Therapy, Physical Therapy,
Speech Language Pathology and Consulting Services
2051 NW 112th Ave #125, Miami, FL 33172-1835
Phone: 305-878-0083 **Fax**: 305-477-7808
Email: awildac@kinetickidstherapy.com, jenniferg@kinetickidstherapy.com

SPEECH QUESTIONNAIRE

CLIENT NAME: _____DATE: _____

INTERVIEWER: _____

INFORMATION PROVIDER: _____

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1. Has your child been seen/tested in any of these areas before or any of these programs?

   Speech and Language _____YES _____NO
   If yes, when, where, and for what reason? (i.e. FDLRS, EIP (Early Steps), CARD)
   _____
   _____
   _____

   Occupational Therapy _____YES _____NO
   If yes, when, where, and for what reason? (I.e. UM CARD, CPT, B & V Thera-Pro)
   _____
   _____
   _____

   Physical Therapy _____YES _____NO
   If yes, when and where? (i.e. Miami Children's Hospital, CPT, B & V Thera-Pro)
   _____
   _____
   _____

   Audiology _____YES _____NO
   If yes, when, where, and for what reason?
   _____
   _____
   _____

   Neurology _____YES _____NO
   If yes, when, where, and for what reason?
   _____
   _____
   _____

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Psychology _____YES _____NO
If yes, when, where, and for what reason?

_____
_____
_____

(Please provide records for any of the above areas tested)

2. Is your child currently receiving speech therapy, physical therapy or occupational therapy?
   _____YES _____NO
   If yes, please provide therapy services, providers, contact numbers and length of time in therapy and days of service at present? (This can effect reimbursement for services and must be completed)

   _____
   _____
   _____

3. Does your child have difficulties in any of the following areas?

Speech and Language	_____YES _____NO
Behavior Difficulties	_____YES _____NO
Feeding and Swallowing	_____YES _____NO
Sleeping	_____YES _____NO
Vision Problems	_____YES _____NO
Hearing Problems	_____YES _____NO
Gross Motor Skills	_____YES _____NO
Fine Motor Skills	_____YES _____NO
Other_____	_____YES _____NO

4. How would you describe your child's language/speech?

   _____
   _____
   _____
   _____

5. How is your child's speech?
   _____ Clear
   _____ Unintelligible

   Familiar listener _____ good _____fair _____poor
   Non-familiar listener _____ good _____fair _____poor

6. At what age did you notice that your child had speech/language difficulties?

   _____
   _____
   _____

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7. How does your child communicate? (Please check all that apply)

_____ Gestures _____Physical Directing _____Vocalizations
_____ Babbling _____Jargon _____One Word Utterances
_____ Two Word Utterances _____Three Word Utterances
_____ Telegraphic Utterances _____ Phrases _____Sentences
_____ Code Mixing _____ Code Switching _____ Other

Additional Information:
_____
_____
_____

8. Does your child have oral motor feeding difficulties?
_____ Pacifier Use _____ Oral Aversion _____ Oral Weakness
_____ Bottle Drinking _____ Thumb Sucking _____ Reflux
_____ Colic _____ Other _____ Drooling

Additional Information:
_____
_____
_____

9. Are the parents bilingual? _____YES _____NO
If yes, what language is spoken most frequently to the child? _____

What language does your child speak most frequently? _____

10. Who is the primary caregiver for the child? _____

Birth History

1. Were you under a physician's care? _____YES _____NO

2. Did you take any medications or drugs during pregnancy? _____YES _____NO

If yes, please indicate: _____

3. Did you smoke? _____YES _____NO

If yes how much? _____

4. Did you drink beer, wine, or alcohol? _____YES _____NO

If yes, how much? _____

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5. Did you have any infections, accidents, illnesses, or injuries during your pregnancy?
   _____YES _____NO
   If yes, please describe:
   _____

   _____

6. Where was your child born?_____

7. Was your delivery premature, normal, cesarean or delayed? _____

   If premature by how many weeks? _____

8. How long was your delivery? _____

9. Did you or the baby have any problems before, during, or after birth? (jaundice, bluish skin, lack of oxygen) _____YES _____NO

   If yes, please explain:
   _____

   _____

10. Did you receive any medications during your delivery? _____YES _____NO

    If yes, what medications did you receive? _____

11. How long was your hospital stay? _____

Developmental History

Birth Weight: _____lbs._____oz.

1. How old was your child when he/she
   - Sat without help _____
   - Began to crawl _____
   - Walked without help _____
   - Said first word (in what language)_____
   - Began to combine two words _____
   - Began to combine three or more words _____

2. Does your child have any sensory developmental difficulties? ____YES ____NO
   If yes, please explain:
   _____
   _____

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3. Does your child have any motor developmental difficulties? ____YES ____NO
   If yes, please explain:
   _____
   _____

4. Which of the following illnesses has your child had?

_____epilepsy/seizures	_____meningitis
_____high fever	_____mumps
_____tonsil infection	_____bladder problems
_____throat infection	_____kidney problems
_____ear infection	_____pneumonia
_____asthma	_____allergic reactions
_____bronchitis	_____frequent colds
_____convulsions	_____measles
_____dehydration	_____chicken pox

5. How many ear infections has your child had? _____

6. Is your child taking any medications? ____YES ____NO
   If yes, please explain:
   _____
   _____

7. Has your child suffered blows to the head or any other accidents? __YES __NO
   If yes, please explain:
   _____
   _____

8. Has your child been hospitalized for any reasons? (i.e. surgery, chronic illnesses)
   ____YES ____NO
   If yes, please explain:
   _____
   _____

Current Functioning and Parents Comments

1. What are your major concerns regarding your child's communication skills at this time?
   _____
   _____

2. How do you discipline your child?
   _____
   _____

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3. Does it work? ____YES ____NO
   If no, please explain:
   _____
   _____

4. What things cause your child to cry?
   _____
   _____

5. What things make your child happy?
   _____
   _____

6. Do you feel your child has any behavioral/emotional problems? ___YES ___NO
   If yes, please explain:
   _____
   _____

7. When did this problem start? _____

8. Are there any other problems or conditions not mentioned above that you feel should be shared?
   ____YES ____NO
   If yes, please explain:
   _____
   _____

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For Clinician Use Only:
Possible etiological factor(s)

_____
_____
_____

Communication Profile

Test	Raw Score	Standard Score	Percentile	Age Equivalency	Severity

Social/Behavioral Observation Checklist

- □ auditory/visually alert and attentive
- □ age appropriate attention span
- □ appropriate attending and responding behaviors
- □ cooperative
- □ friendly
- □ sociable
- □ interactive
- □ appropriate use of eye contact
- □ easily separated from parents
- □ well behaved
- □ other:
- □ other:
- □ other:
- □ auditory/visually alert yet inattentive
- □ short attention span
- □ inconsistent attending and responding behaviors
- □ uncooperative
- □ fussy/irritable
- □ immature
- □ non-interactive
- □ poor use of eye contact
- □ hyperactive
- □ distractible
- □ impulsive
- □ restricted affect
- □ separation anxiety

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Vocal parameters:

Quality	□ functional	□ other _____
Resonance	□ functional	□ other _____
Pitch	□ functional	□ other _____
Intensity	□ functional	□ other _____

Complete vowel repertoire? □ yes □ no
Consonant repertoire appropriate to age? □ yes □ no
If not, explain.

Speech-sound misarticulations/phonological processes identified (if applicable):

Omissions:
Initial word position
Medial word position
Final word position

Substitutions:
Initial word position
Medial word position
Final word position

Recommended referrals:

□ Continued school attendance
□ Re-evaluation of current educational placement
□ Pre-school enrollment
□ Neurological evaluation
□ Psychological evaluation
□ Psycho educational evaluation
□ Occupational therapy evaluation
□ Physical therapy evaluation
□ Feeding/Swallowing evaluation
□ ENT evaluation
□ Communication re-evaluation____ 6 mo____ 12 mo
□ Other:_____