KidSPOT pediatric therapies

Family Interview - SLP

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Child's Name: ______________________ **DOB:** ____________

Primary Concerns

Describe your child's speech problem: ____________________

When did you first notice a speech problem? ____________________

Does anyone else in your family have a speech, language, hearing, or learning problem?

If yes, please describe: ____________________

Health and Developmental History

Did you have a normal pregnancy? ☐ Yes ☐ No Length of pregnancy: ________

If no, please list any problems: ____________________

Describe your child's delivery and birth?
☐ Typical ☐ Spontaneous ☐ Induced ☐ Cesarean ☐ Breech ☐ Unusually long labor

What was your child's birth weight? ____________ APGAR Score: ________

Does your child have a history of any of the following? (Check all that apply)

☐ Drooling	☐ Ear Tubes	☐ Intubation/Ventilator
☐ Ear Infection	☐ Surgery	☐ Hospitalization
☐ Allergies	☐ Chronic or Severe Illness	☐ Seizures
☐ Asthma	☐ High or Prolonged Fever	☐ Head Injury
☐ Hearing Loss	☐ Reflux	☐ Serious Accidents

Please explain any of the above as needed: ____________________

List any medication(s) your child is currently taking: ____________________

What is your child's current state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has your child ever had a hearing evaluation? ☐ Yes ☐ No
If yes, list date(s) and results: ____________________

Does your child have a history of feeding problems? If yes, check all that apply:

☐ Choking	☐ Difficulty Biting	☐ Overstuffing Mouth
☐ Poor Nursing	☐ Difficulty Chewing	☐ Difficulty Swallowing
☐ Other: ________		

Is your child a messy, or picky eater? ____________________

At what age did your child attain these developmental milestones:
Sitting: ________ Walking: ________ Toilet Training: ________
First Words: ________ First Sentences: ________

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Speech and Language

Did your child babble? ☐ Yes ☐ No

If yes, did he/she use a variety of sounds when babbling? ☐ Yes ☐ No

What were your child's first words?____________________

Once your child started to use words, did he/she continue to add new words to his/her speaking vocabulary on a weekly basis? ☐ Yes ☐ No

Does your child have a history of using a word once or several times, and then never using it again?: ☐ Yes ☐ No

If yes, please give examples:____________________

Is your child reluctant to communicate or become frustrated when trying to speak?
☐ Yes ☐ No

If yes, please describe:____________________

Is your child reluctant to imitate speech sounds or words? ☐ Yes ☐ No

If yes, does he/she refuse these types of tasks? ☐ Yes ☐ No

Does it seem that your child has more difficulty producing understandable speech on some days and not others or at certain times? ☐ Yes ☐ No

If yes, please explain any consistencies you may have noticed:____________________

____

How would you describe your child's speech errors?
☐ Consistent ☐ Change from word to word and/or day to day

Circle the speech sounds your child currently uses:

VOWELS Long: a c i o u Short: a e I o u

CONSONANTS p b m w t d n f v k g

h s z sh ch j y l r th

Approximately how much of your child's speech do you understand?
☐ Less than 25% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Can people outside the family understand your child's speech? ☐ Yes ☐ No

How would you describe the melody and rhythm of your child's speech?
(Check all that apply)

☐ Smooth ☐ Slow ☐ Soft ☐ Loud ☐ Lacking in Intonation
☐ Halting ☐ Fast ☐ Choppy ☐ Lacking in Pitch Changes

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Speech and Language Continued

How does your child typically communicate with others? (Check all that apply)

☐ Talking (whether understandable or not) ☐ Pointing ☐ Gestures ☐ Crying
☐ Pulling/taking adult to what he/she wants ☐ Signs ☐ Pictures ☐ Other: ____________
☐ Voice Output Speech Device ☐ Facial Expressions

Does your child play and communicate well with his/her friends and family? ☐Yes ☐No
If no, please describe: ______________________________

Does your child seem to understand most of what you say & tell him/her to do? ☐Yes ☐No

Does your child have difficulty following directions? ☐ Yes ☐ No
If yes, please describe: ______________________________

How many words does your child now use?

☐0-20 ☐20-50 ☐100-150 ☐150-200 ☐200+

If you child uses phrases and sentences, how long are they on average?

☐ 2 words ☐ 3 words ☐ 4 words ☐ 5 words ☐ longer than 5 words

Does your child (check yes or no for each)	Yes	No
Ask questions to gain information	☐	☐
Understand vocabulary	☐	☐
Use age-appropriate vocabulary	☐	☐
Stay on subject in a conversation	☐	☐
Take turns when talking to someone	☐	☐
Describe and explain	☐	☐
Answer questions	☐	☐
Have difficulty putting words together into a sentence	☐	☐
Leave words out of sentences	☐	☐
Use correct grammar such as plurals, verb tenses, pronouns	☐	☐

Voice and Fluency

Is your child's voice clear? ☐Yes ☐No
If no, please describe: ______________________________

Describe your child's voice. (Check all that apply)

☐ Nasal ☐ Monotone ☐ High-pitched ☐ Low-pitched
☐ Soft ☐ Loud ☐ Breathy ☐ Hoarse
☐ Denasal (sounds like he/she has a cold)

Does your child talk smoothly without repeating sounds or words? ☐Yes ☐No
If no, does he/she have trouble getting words out? ☐Yes ☐No
If yes, please describe: ______________________________

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Auditory Processing and Learning

Does your child have difficulty with any of the following? (Check all that apply)

- ☐ Memory Tasks
- ☐ Comprehension
- ☐ Word Retrieval
- ☐ Remembering and following directions
- ☐ Putting thoughts together
- ☐ Difficulty learning/using new vocabulary

Does your child have difficulty learning early academic skills such as matching, identifying same/different, and/or knowing names of colors, shapes, numbers and letters? ☐Yes ☐No

If yes, please describe:______________________________

Does your child have difficulty learning skills in reading, math, spelling, other? ☐Yes ☐No

If yes, please describe:______________________________

Is your child receiving special help with learning skills? ☐Yes ☐No

If yes, please explain:______________________________

Do you have concerns about your child's learning skills? ☐Yes ☐No

If yes, please explain:______________________________

Sensory and Motor

Does your child have any difficulty walking, running, sitting, or other large motor skills?

If yes, please describe:______________________________

Is your child clumsy or does he/she fall easily? ☐Yes ☐No

Does your child have low body tone? ☐Yes ☐No

Does your child have difficulty with fine motor skills such as stacking, cutting, and handwriting? ☐Yes ☐No

If yes, please describe:______________________________

Is your child sensitive to certain textures of food or clothing? ☐Yes ☐No

If yes, please explain:______________________________

Does your child dislike having substances on his/her hands (e.g. glue or dirt)? ☐Yes ☐No

Is your child oversensitive to being touched/dislikes being touched? ☐Yes ☐No

If yes, please describe:______________________________

Check all that apply regarding your child:

- ☐ Dislikes washing his/her face or hair
- ☐ Puts things in his/her mouth besides food
- ☐ Spends too little or too much time brushing his/her teeth
- ☐ Does not demonstrate caution
- ☐ Dislikes haircuts
- ☐ Chews on his/her clothes

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Behavior

Does your child typically display any of the following behaviors? (Check all that apply)

- ☐ Difficulty staying on task
- ☐ Tantrums
- ☐ Sensitive
- ☐ Difficulty finishing tasks
- ☐ Passive in interactions
- ☐ Very active
- ☐ Underactive
- ☐ Angry/acting out behavior
- ☐ Frustrated
- ☐ Inattentive
- ☐ Refuses to perform tasks
- ☐ Shy
- ☐ Reduced or lack of interaction with others

Other Information

Who does your child play with? (Check all that apply)

- ☐ Both parents
- ☐ Grandparents
- ☐ Foster parents
- ☐ Mother only
- ☐ Father only
- ☐ Parent + Stepparent
- ☐ Other: ____________________

Are languages other than English spoken in the home? ☐Yes ☐No
If yes, please list:____

Has your child had previous speech-language therapist? ☐Yes ☐No
If yes, please list dates, setting(s), and therapist(s):______________________________
____

If your child had speech-language therapy, what kind of progress did your child make?
____

Were you pleased with your child's progress? ☐Yes ☐No
Please explain:____

Has your child been evaluated by any other professional: (Check all that apply)

- ☐ Educator/Teacher
- ☐ Occupational Therapist (OT)
- ☐ Neurologist
- ☐ Geneticist
- ☐ Psychologist/Psychiatrist
- ☐ Physician
- ☐ Physical Therapist (PT)
- ☐ Other: ______________________________
- ☐ Developmental Pediatrician (Specialist)

Does your child have a diagnosis from any of the above professionals? ☐Yes ☐No
If yes, please list date, professional, and diagnosis for each:______________________________
____

What other concerns do you have about your child?______________________________
____

What do you consider to be your child's greatest strengths?______________________________
____

What do you hope to gain from this evaluation?______________________________
____

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