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Speech and Language Background and Parent Report

(Please complete all areas relevant to your child.)

Child's Name: _____Child's Age: _____
Completed By: _____Date of Completion: _____

GENERAL INFORMATION

1.My child has previously been evaluated for speech and language concerns. Y/N
When?_____ Where? _____
Do you have a copy of the report? Y/N
(If yes, please bring a copy with you to your child's evaluation.)

2. My child has difficulty with attention to task. Y/N
Describe:

_____

3. Please describe the circumstances in which your child will perform his/her best during this evaluation :(Ex. Sensory needs, reward system, environmental accommodations, etc.)

_____

_____

4. My child has had a hearing screening. Y / N Did they pass? Y / N
Describe:

_____

5. My child is receiving speech and language services at another location (i.e. clinic or school) Y / N
If yes, how often?

_____

What is being addressed?

_____

6. What language(s) is/are spoken at home?_____

7. Is there any history of speech or language problems in the family? Y / N If yes, please describe:

8. Is there any history of hearing problems in the family? Y / N If yes, please describe:

9. Describe any significant family medical, learning, or emotional history.

10. What are your primary concerns regarding your child's development?

ORAL/FEEDING HABITS

1. Has your child had any feeding difficulties? (e.g., drooling, swallowing). Y / N If yes, describe:

2. Does she/he avoid any foods? Y/N If yes, describe:_____
3. When did your child wean from a bottle? _____
4. Did your child use a sippy cup for more than 3-6 months? Y / N_____
5. Does your child use a straw to drink liquids? Y / N
6. When did your child stop sucking his/her thumb or digits?

7. Did your child use a pacifier? Y / N If so, for how long? _____
8. Does your child grind his/her teeth or tense their jaw? Y/N If so, at what times?

9. Does your child exhibit open mouth posture and/or breathe primarily through their mouth? Y / N
10. Is your child sensitive to textures? Y / N
11. Is your child sensitive to sounds? Y / N
12. Does your child exhibit any self-stimulatory behaviors? Y / N If yes, describe:

SPEECH/ARTICULATION

Circle: Area of Concern Not Applicable

1. My child has difficulty producing the following sounds:_____
2. My child can accurately imitate most sounds in words. Y/N
3. My child is _____% understandable to familiar listeners (i.e. family members).

LANGUAGE (Receptive/ Expressive)

Circle: Area of Concern Not Applicable

Receptive Language:

1. My child can follow multi-step directions. Y/N

Describe: _____

2. My child can identify objects and actions. Y/N
Describe:

_____

3. My child can answer yes/no and WH-questions appropriately. Y/N
Describe:

_____

4. Other concerns associated with comprehension of language:

_____

Expressive Language:

1. My child primarily communicates their wants and needs by:
Circle: verbalizing words pointing/pulling/reaching sign language
2. If your child's vocabulary consists of one word utterances or signs, describe which words and signs your child is consistently using:

_____

3. If your child is independently combining words or signs: My child uses sentences that are approximately _____ words/signs in length.
4. My child can imitate words and sentences. Y/N
5. Other concerns associated with expressive language:

_____

PRAGMATICS/SOCIAL SKILLS

Circle: Area of Concern Not Applicable

1. My child is engaged in his/her environment. (ex. following objects with eyes, engaging with toys and people in play) Y/N
   Describe:

   _____
2. My child uses greetings and farewells. Y/N
   Describe:

   _____
3. My child will participate in turn taking. Y/N
   Describe:

   _____
4. My child has difficulty transitioning into new environments or situation. Y/N
   Describe:

   _____
5. My child has difficulty engaging with other children and understanding play. Y / N
Describe:

_____

6. My child struggles to understand social situations and adjust his/her behavior appropriately. Y / N Describe:

_____

FLUENCY/STUTTERING

Circle: Area of Concern Not Applicable

1. My child repeats: Parts of words Y /N Whole Words Y / N Phrases Y /N
2. My child shows tension and/or pauses during his/her speech. Y / N
3. My child is aware of his/her dysfluency. Y/N
   Describe:

   _____
4. My child is self-conscience of their dysfluency. Y/N
5. Please describe any differences in your child's fluency based on environment, situation or topic.

   _____

READING/ SPELLING

Circle: Area of Concern Not Applicable

1. I have concerns with my child's ability to identify/ label letters. Y/N
2. I have concerns with my child's ability to associate sounds with letters. Y/N
3. I have concerns with the child's ability to sound out words or recognize sight words. Y/N
   Describe: _____
4. I have concerns with my child's reading rate. Y/N
5. I have concerns with my child's comprehension of written material. Y/N
   Describe: _____

AUDITORY PROCESSING/ EXECUTIVE FUNCTIONING/ WORKING MEMORY

Circle: Area of Concern Not Applicable

1. My child struggles to organize his/her thoughts. Y/N
Describe:

_____

2. My child is disorganized with his/her thoughts when speaking. Y/N
Describe:

_____

3. My child struggles with problem solving, humor, prediction and/or inferring. Y / N
Describe:

_____

4. My child struggles to remember information just provided, and may struggle with being able to use manipulate or use that information functionally. Y/N
Describe:

_____

5. Please list any other concerns you may have:

_____

_____