Advanced Therapy Solutions

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?

_____

_____

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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:

_____

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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: _____

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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:

_____

_____

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