RiteCare SPEECH AND LANGUAGE THERAPY OF WASHINGTON
Childhood Speech and Language Programs

Developmental Questionnaire

I. Identifying Information: Date of Application:_____

Child's Name _____ Birthdate _____ Sex ☐ M ☐ F

Address_____

City_____ State_____ Zip_____

Home Phone_____ Child's Place of Birth_____

Name of person filling out form:_____Relationship to Child _____

II. Family Information

1. Mother's Name_____ Father's Name_____

Mailing Address (if different from child) Mailing Address (if different from child)

_____ _____

_____ _____

E-Mail Address_____ E-Mail Address_____

Cell Phone #_____ Cell Phone #_____

Home Phone #_____ Home Phone #_____

Work Phone #_____ Work Phone #_____

Employer's Name_____ Employer's Name_____

2. Names of all people living in the home:

Name	Relationship to Child	Age	Education Level

3. Has there been, or is there anyone else in the family with a problem similar to that of your child?

Please briefly describe._____

4. Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one?_____

Does the child speak the language? ☐ Yes ☐ No

Does the child understand the language? ☐ Yes ☐ No

Who speaks the language? _____

Which language does the child prefer to speak at home?_____

III. Statement of Problem

1. Please describe your child's speech issues. _____

   _____

2. Has he/she ever had a speech evaluation/screening? ☐ Yes ☐ No

   If yes, where and when? _____

   What were you told? _____

   _____

3. Has your child ever had speech therapy? ☐ Yes ☐ No

   If yes, where and when? _____

   What was he/she working on? _____

   _____

4. Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? ☐ Yes ☐ No

   If yes, please describe. _____

   _____

IV. Medical and Birth History

1. Child's current physician _____

   Address _____ City _____ State _____ Zip _____

2. Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No

   If Yes, please explain. _____

   _____

3. Length of pregnancy _____ Birth weight _____

4. Is child adopted? ☐ Yes ☐ No

   If Yes, from what country? _____ Age at adoption _____

5. Describe any unusual medical conditions or events that occurred to the child and at what age:

   _____

   _____

6. Has your child had any of the following?

☐ adenoidectomy	☐ encephalitis	☐ seizures
☐ allergies	☐ flu	☐ sinusitis
☐ breathing difficulties	☐ head injury	☐ sleeping difficulties
☐ chicken pox	☐ high fevers	☐ thumb/finger sucking habit
☐ colds	☐ measles	☐ tonsillectomy
☐ ear infections	☐ meningitis	☐ tonsillitis
How often? _____	☐ Mumps	☐ vision problems
☐ ear tubes	☐ scarlet fever	☐ whooping cough

7. Has your child had a hearing test? ☐ Yes ☐ No If Yes, when? _____

Where?_____ Results?_____

8. Does your child take medications regularly? ☐ Yes ☐ No

If Yes, what kind(s) and why?_____

_____

V. Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____ babbled
_____ said first words
_____ put two words together
_____ spoke in short sentences
_____ sat alone
_____ walked
_____ grasped crayon/pencil
_____ toilet trained

Do you feel child is well-coordinated? ☐ Yes ☐ No

Does your child...

☐ choke on food or liquids
☐ feed self with utensils
☐ brush his/her teeth and/or allow brushing
☐ drink from an open cup
☐ currently put toys/objects in his/her mouth

VI. Current Speech-Language-Hearing

Does your child...

☐ repeat sounds, words or phrases over and over
☐ understand what you are saying
☐ retrieve/point to common objects upon request (ball, cup, shoe)
☐ follow simple directions ("Shut the door" or "Get your shoes")
☐ respond correctly to yes/no questions
☐ respond correctly to who/what/where/when/why questions

Your child currently communicates using...

☐ body language
☐ words (shoe, doggy, up)
☐ sentences longer than four words
☐ sounds (vowels, grunting)
☐ 2 to 4 word sentences
☐ other _____

Behavioral Characteristics:

☐ cooperative
☐ attentive
☐ willing to try new activities
☐ plays alone for reasonable length of time
☐ separation difficulties
☐ easily frustrated/impulsive
☐ stubborn
☐ restless
☐ poor eye contact
☐ easily distracted/short attention
☐ destructive/aggressive
☐ withdrawn
☐ inappropriate behavior
☐ self-abusive behavior

Comments_____

_____

_____

What are child's favorite activities?_____

VII. School History

If your child is in school, please answer the following:

1. Name of school and current grade_____

   Address_____ Phone_____

   School District _____ Teacher _____

2. Is your child in a special school program? ☐ Yes ☐ No

   Please describe_____

   _____

   Special services at school: (circle) OT PT Speech Therapy Special Reading Math

   Other_____

3. What do you see as your child's most difficult problem in school?_____

   _____

VIII. Miscellaneous

1. Is there anything else regarding your child that you are concerned with?_____

   _____

2. Please give any additional information which might help us know your child better._____

   _____

3. Transportation to and from the clinic on a regular basis as needed for therapy would be:

   ☐ No problem ☐ some problem ☐ major problem ☐ Not possible

When all sections of the questionnaire are completed, please send to the appropriate clinic.

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If we have not received a response from you in three (3) months your personal health information will be deleted from our system.