PROVIDENCE SPEECH AND HEARING CENTER
1301 PROVIDENCE AVE.
ORANGE, CA 92868 (714) 923-1521

CONFIDENTIAL CHILD QUESTIONNAIRE

I. General Information

Child's Name: ______________________________ Birth date: _________________________

Address: ____

Home Phone #: ________________________________ Cell #: ____________________________

Mother's Name: _______________________________ Father's Name: ______________________________

Address: ______________________________________ Address: ___________________________________

Phone #: ______________________________________ Phone #: ___________________________________

Employer: _____________________________________ Employer: __________________________________

Child's siblings: ____

Other persons living in child's home: ____

Child's Physician: _____________________________Phone #: ___________________________

Address: ____

Referred to center by: ____________________________ for: _______________________________

II. Background Information

Describe the problem: ____

When was the problem first noticed? ____

Who first noticed the problem? ____

Have there been any changes to your child's speech, language or hearing since that time? Yes __ No __

If yes, please explain: ____

____

Has a Medical Professional been consulted regarding this problem? Yes ____ No ____

If yes, by whom? Providers Name: ____________________________________

Providers Address: ___________________________________

____

____

Providers Phone Number: _____________________________

Providers Fax Number: _______________________________

What were the results of this evaluation? ____

____

Has your child ever had an evaluation from an Ear, Nose, or Throat Medical Doctor? Yes ___ No ___

If yes, by whom? Providers Name: _____________________________________

Providers Address: ___________________________________

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____

Providers Phone Number: ____________________________

Providers Fax Number: ______________________________

What were the results of this evaluation? ____

____

Has your child ever had a speech/language Evaluation? Yes ____ No ____

If yes, by whom? Providers Name: _____________________________________

Providers Address: ___________________________________

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____

Providers Phone Number: ____________________________

Providers Fax Number: ______________________________

What were the results of this evaluation? ____

____

Has your child ever had a physical therapy or occupational therapy evaluation? Yes ____ No ____

If yes, by whom? Providers Name: ___________________________________

Providers Address: ___________________________________

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Providers Phone Number: ___________________________

Providers Fax Number: ____________________________

What were the results of this evaluation? ____

____

A. Speech/Language/Hearing History

1. What languages are spoken at home? 1st: ___________________ 2nd: ___________________
2. At what age did your child babble? ____
3. When did your child say his/her first word? ____
4. When did your child begin use two word phrases? ____
5. When did your child begin to use sentences? ____
6. How well can he/she be understood by parents? ____
7. By other family? ____
8. By new people? ____
9. How many words are in the child's vocabulary? ____
10. Which does this child use to communicate? ☐Sentences ☐Phrases

    ☐One-Two words ☐Sounds ☐Gestures
11. Do you question your child's ability to understand directions/conversation? Yes ___ No ___

    If yes, Why? ____
12. Do you question your child's ability to express him or herself? Yes ___ No ___ if yes, why?

    ____
13. Do you have concerns regarding your child's voice or fluency? Yes ___ No ___ if yes, explain.

14. Do you have concerns regarding your child's hearing? Yes ___ No ___ If yes, explain.

15. Has your child's hearing ever been tested? Yes ___ No ___ If yes, please include date and results.

16. Has your child's vision ever been tested? Yes ___ No ___ If yes, please include date and results.

B. Medical/ Family History

1. Did mother have any of the following during pregnancy:

- ☐ Bleeding
- ☐ Virus Infection
- ☐ Swelling
- ☐ German Measles- Rubella
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Low blood pressure
- ☐ Heart Condition
- ☐ Convulsions
- ☐ Asthma
- ☐ Excessive weight gain/loss
- ☐ Thyroid condition
- ☐ Toxemia
- ☐ Kidney disease
- ☐ Medications
- ☐ Accidents
- ☐ Anesthetics
- ☐ Surgeries
- ☐ Drinking alcohol
- ☐ Smoking

2. What was length of pregnancy? ______________________________

3. What was length of labor? ______________________________

4. What was type of delivery? ☐ Normal ☐ Breech ☐ Caesarian ☐ Dry ☐ Other

5. Were there any unusual problems during delivery? Yes ___ No ___ If yes, please describe.

6. Were forceps' used? Yes ___ No ___ Any bruising? Yes ___ No ___

7. Birth weight? Lbs. ____ Oz. ____

8. During first couple weeks of life, did your child have <u>problems</u> with any of the following?

☐ Feeding/swallowing ☐ Convulsions ☐ Severe Jaundice ☐ Serious infections

☐ Heart or breathing ☐ Severe Reflux ☐ Other ______________________________

9. How long did your child remain in the hospital? ______________________________

10. Has your child experienced any of the following? Please include age and severity.

☐ Mumps ______________________________

☐ Measles ______________________________

☐ Chicken Pox ______________________________

☐ Pneumonia ______________________________

☐ Influenza ______________________________

☐ Headaches ______________________________

☐ Sinus ______________________________

☐ Meningitis ______________________________

☐ Dental Problems ______________________________

☐ Ear Infections ______________________________

☐ Draining Ears ______________________________

☐ P.E. Tubes Insertion ______________________________

☐ Tonsillectomy ______________________________

☐ Adenoidectomy ______________________________

☐ Allergies ______________________________

☐ Epilepsy ______________________________

☐ Encephalitis ______________________________

☐ Tonsillitis ______________________________

☐ Chronic Colds ______________________________

☐ Head Injuries ______________________________

☐ Asthma ____

☐ Other Illnesses/ Surgeries ____

11. Is your child presently taking any medication? Yes ___ No ___ If yes, please include name and purpose. ____

12. Has anyone else in your family had speech, language or hearing problems? If so, describe who had the problem, what the problem was, and how it was helped? ____

    ____

13. Have any of the following conditions affected members of your immediate family?

    ☐ Deafness ☐ Neurologic ☐ Diseases ☐ Cleft Lip/Palate

    ☐ Stuttering ☐ Delayed Speech ☐ Delayed Motor Skills

    ☐ Other ____

14. Does your child have any difficulty swallowing? Such as coughing, choking on food or liquid, etc. If yes, please describe. ____

    ____

C. Social/Behavioral/Educational History

15. Does your child prefer to play alone or with other children? Yes ___ No ___ If yes, briefly describe.

    ____

    ____

16. Does your child have temper tantrums? Yes ____ No ____

17. Does your child get along with others? Yes ____ No ____

18. Is your child unusually quiet or unusually active? Yes ____ No ____

19. Does your child have difficulty attending or following your directions? Yes ____ No ____

20. Does your child have difficulty tolerating transitions or unexpected changes to his/her routine?

    Yes ____ No ____

21. Is there anything about your child's behavior that concerns you? Yes ____ No ____ If yes, please explain. ____

22. Does your child attend school or daycare? Yes ___ No ___ If yes, please include name and grade.

____

D. Occupational/Developmental/Adaptive Development

1. Please state how your child does at being/doing the following (e.g. good, fair, poor, not yet, not applicable, etc.) Peer/Friend/Playmate __________ Student __________

   Child/Family Member/Sibling _____________ Eating and Feeding him/herself _____________

2. At what age did your child do the following on his/her own?

   Roll __________ Sit __________ Crawl __________ Stand __________ Walk __________

3. Describe how well your child does the following:(e.g. Good, needs some help, not at all, etc)

   Drinking from open Cup _______________ Eating from utensil ____________________

   Brushing hair _________________________ Brushing teeth _________________________

   Taking off shoes/socks _________________ Putting shoes/socks on _________________

   Taking off shirt/pants __________________ Putting shirt/pants on __________________

   Managing fasteners (i.e. zippers, snaps, laces etc.) _______________________________________

   Using the toilet ________________________

E. Sensory Processing

1. Check all that apply:

   - ☐ Licks or smells non food items
   - ☐ Avoids certain foods
   - ☐ Enjoys playground play (swings, slides)
   - ☐ Avoids having feet off ground
   - ☐ Takes risks during play
   - ☐ Prefers activities that are less active
   - ☐ Walks on toes
   - ☐ Avoids being barefoot on some surfaces
   - ☐ Seeks out hugs/touch/rough play
   - ☐ Resists being touched/hugged
   - ☐ Seems weak or seems to easily
   - ☐ Seems clumsy; uncoordinated; falls easily
   - ☐ Avoids or is upset by being messy
   - ☐ Gets upset by certain noises

2. Any additional information or comments that you think might be helpful.

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______________________________ ______________________________
Signature Relationship to child

____
Date

PLEASE DON'T FORGET TO FAX OR BRING WITH YOU ANY AND ALL EVALUATION REPORTS OF ANY KIND SUCH AS IEPs, HEARING, PT OR OT. THANK YOU!

CONSENT TO RELEASE MEDICAL HISTORY

______________________________ __________________________

Patient Name: Date of Birth:

_________________________ __________________________

City: State:

____

Date:

To Whom is May Concern:

This authorizes all physicians, hospitals, and medical attendants to furnish any and all medical records, history and information to Providence Speech and Hearing Center, or to any representative of Providence Speech and Hearing Center, concerning my medical condition. This authorization also includes examination of all hospital records, x-ray film, and furnishing of any information including opinions. You are further requested not to disclose such information to any other person without written authority to do so.

All prior authorization is hereby cancelled.

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Patient / Parent / Legal Guardian