SHINING STARS
Pediatric Therapy
SERVICES

304 Judd Place Drive Fuquay Varina, NC 27526
Phone (919)557-8305 Fax (919) 557-8306

SHINING STARS THERAPY SPEECH INTAKE QUESTIONNAIRE

Child's Name: _____ Date of Birth:_____

Address: _____ Phone: _____

City: _____ Zip Code: _____

Referred by: _____

Pediatrician : _____

Is there a familial history of speech and language delays? If yes, please describe.

What language does the child speak? What is the child's primary language?

What languages are spoken in the home? What is the primary language?

With whom does the child spend most of his or her time?

Describe the child's speech and language problem.

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How does the child usually communicate (gestures, single words, short phrases, sentences)?

When was the problem first noticed? By whom?

What do you think may have cause the problem?

Has the problem changed since it was first noticed?

Is the child aware of the problem? If yes, how does he/she feel about it?

Have any other speech language specialists seen the child? Who and when? What were the conclusions and suggestions?

Have any other specialists (physicians, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen and the specialist's conclusions or suggestions.

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Mother's general health during pregnancy:

Length of pregnancy: _____ Length of labor: _____

General condition: _____ Birth weight: _____

Were there any unusual conditions that may have affected the pregnancy or birth?

Has the child had any surgeries? If yes, what type and when?

Describe any major accidents or hospitalizations

Is the child taking any medications? If yes, identify.

Have there been any negative reactions to medication? If yes, identify.

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Provide the approximate age at which the child began to do the following activities:

Crawl:_____ sit:_____ Stand: _____

Walk:_____ Feed self:_____ Dress self: _____

Use single words: _____

Combine words: _____

Does the child have difficulty walking or running?

Are there or have there been any feeding problems? If yes, describe.

Describe the child's response to sound (respond to all sounds, respond to loud sounds only, inconsistently responds to sounds, etc.)

Has you child had a complete audiological evaluation? Have they had their hearing screened at the doctor's office? If so, what were the results?

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EDUCATIONAL HISTORY:

School: _____ Grade: _____

How is the child doing academically?

Does the child receive speech services? If yes, describe the services.

How does the child interact with others?

If enrolled for special education services, has an IEP been developed? Describe the most important goals.

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

Person completing form: _____

Relationship to the child: _____

Signed: _____ Date: _____