

## SPEECH THERAPY EVALUATION QUESTIONNAIRE

1. Reason for ST referral?
2. How long have you noticed there was a problem?
3. How does your child tell you what he/she wants? (i.e. grunts, points, uses words, etc.)
4. Do you have difficulty understanding your child?
5. Can your child follow directions? (i.e. "Go to the kitchen and bring me a fork.")
6. Have you noticed any drooling or difficulty chewing or swallowing foods?
7. Does your child go to preschool/Headstart or daycare? If so,
  - a. Where?
  - b. How often?
  - c. Do they receive ST services at school?
    - i. Therapists name \_\_\_\_\_
8. What are some things your child likes to do or toys he/she likes to play with at home?
9. Is your child on medication? Please list name, what it is for, and side effects (if any).
10. Are there any other problems/difficulties that we should be aware of before the evaluation? (i.e. vision, hearing, motor, behavior)
11. Has your child had any other evaluation (OT, PT, psychological, swallowing, augmentative device, audiological, etc.)?

**PLEASE BRING A COPY OF ANY REPORT(S) TO THE EVALUATION**