# Dear Parent or Guardian,

The enclosed packet of information has been sent to you to complete and return following the request for a child speech-language evaluation/treatment at the ETSU Speech-Language-Hearing Center. Your child’s evaluation appointment will not be scheduled **until the completed information packet and the demographics have been returned and we have received a referral from your child’s primary care physician.** Once the packet is received, you will be contacted to schedule the appointment or if there are no available appointments at that time, your child will be put on a waiting list.

We do file insurance however if you do not have insurance or have an insurance that will not pay for our services we do have a Sliding Scale Discount you may apply for. The Sliding Scaled is based on household income/members; if you wish to apply for it please request a form to be mailed to you, fill it out completely and mail it back to me with your proof of income attached. **If your insurance requires prior authorization, it is your responsibility to make sure that we have it before the first visit.** Payment of the clinic fee is expected at the time services are rendered. We accept cash, personal check, and Visa/MasterCard credit cards.

If your child has had previous speech-language evaluations or therapy, a copy of the report(s) would be helpful. You may make arrangements to have them directly mailed to our clinic at the address above or you may bring them with you on the day of the appointment.

On the day of your child’s appointment, please park in a Lamb Hall Clinic (limited) space in front of the building or a faculty/staff or student space. **You may only park in a handicap space if you have the federally approved handicap hangtag or handicap license plate, you may not park in “No Parking” spaces or time limited spaces (ex. 20 minute parking only).**When you check in, the clinic staff will give you a Temporary Parking Permit that you will have to take back to your vehicle before your child’s appointment or you can get a Permit at the Parking Office at 908 West Maple to avoid a parking ticket.

The ETSU Speech-Language Hearing Center is located in Lamb Hall on the 3rd floor, room 363. Please check in at the check-in window. If you need more detailed directions, please call the clinic office at (423) 439-4355.

Thank you for your interest in the ETSU Speech-Language-Hearing Center. Please do not hesitate to contact me if you have any questions or need additional information. We look forward to seeing you.

Sincerely,

Angela Rosenbalm B.B.A.

Clinic Office Manager

Speech-Language-Hearing Clinic

**East Tennessee State University**

**Speech-Language-Hearing Clinic**

**Box 70643**

**Johnson City, TN 37614**

**Child Clinic**

Child History Questionnaire

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Name of person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:

Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number Street

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

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**I.** **IDENTIFYING INFORMATION:**

Child for who the appointment is requested:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City State Zip Code

Telephone: (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Area code) number (Area code) number

**II. REFERRED BY:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(e.g., teacher, speech-language pathologist, audiologist, doctor)

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code (Area code) number

**III. HOME AND FAMILY**

Mother’s age: \_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s age: \_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child lives with: Both Parents\_\_\_\_\_\_Father\_\_\_\_\_\_ Mother\_\_\_\_\_\_Other\_\_\_\_\_\_\_

If other than the natural parents or guardians, please give names and relationship:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the child adopted? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

If yes, at what age was the child adopted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brothers and Sisters:

Name: Age: Grade in school Any communication problems?

Member of household other than family already listed?

Is English the only language spoken in the home? Yes\_\_\_\_\_ No\_\_\_\_\_

If not, what other languages are spoken? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who speaks the language(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a history of any hearing, speech/language, or developmental problems in the family?

Yes: \_\_\_\_\_\_ No: \_\_\_\_\_

If yes, please describe briefly:

**IV. PREGNANCY, BIRTH, AND EARLY DEVELOPMENT:**

**Pregnancy:**

1. Lengths of pregnancy in months: \_\_\_\_ Number of pregnancy preceding this one: \_\_\_

2. Mother’s Health during pregnancy: (please circle) good fair poor

3. Any illnesses or accidents during pregnancy? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please describe briefly:

4. Were any drugs/medications taken by the mother during pregnancy? Yes\_\_\_ No\_\_\_

If yes, please list medications taken:

5. Age of mother at child’s birth: \_\_\_\_\_\_\_\_ Age of father at child’s birth: \_\_\_\_\_\_\_\_

6. Was there a blood (Rh factor) incompatibility? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

**Birth**

1. Length of labor in hours: \_\_\_\_\_\_\_\_\_\_

2. Any unusual problems at birth (e.g., breech, Caesarian section)? Yes\_\_\_\_\_ No\_\_\_\_

If yes, please describe:

3. What drugs or anesthetics (if any) were used during labor and/or delivery? \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Did your child require oxygen? Yes:\_\_\_\_\_ No:\_\_\_\_\_

5. Was your child “blue” or jaundiced (yellow) at birth? Yes\_\_\_\_\_ No:\_\_\_\_\_

6. Were there any injuries, scars, or deformities observed at birth? Yes\_\_\_\_ No\_\_\_\_

If yes, please describe:

7. Child was born in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital City State

8. Were there any problems immediately after birth or during the first two weeks of your child’s life? Yes: \_\_\_\_\_\_ No: \_\_\_\_\_\_

If yes, please describe:

**Early Development:**

1. Please check the box at which your child performed the following action (ages in months)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Action** | **1-3** | **4-6** | **7-9** | **10-12** | **13-18** | **19-24** | **25-36** |
| Kicking, Squirming |  |  |  |  |  |  |  |
| Grasping Tightly |  |  |  |  |  |  |  |
| Flipping from Back to Belly |  |  |  |  |  |  |  |
| Sitting Alone |  |  |  |  |  |  |  |
| Belly Scooting/ Creeping |  |  |  |  |  |  |  |
| Crawling |  |  |  |  |  |  |  |
| Standing Alone |  |  |  |  |  |  |  |
| Walking Alone |  |  |  |  |  |  |  |
| Running |  |  |  |  |  |  |  |
| Feeding Self |  |  |  |  |  |  |  |
| Dressing Self |  |  |  |  |  |  |  |
| Bladder Trained |  |  |  |  |  |  |  |
| Stool Trained |  |  |  |  |  |  |  |

2. Which hand does your child prefer? Right\_\_\_\_\_ Left\_\_\_\_\_

3. Is your child’s coordination: Good\_\_\_\_\_ Fair\_\_\_\_\_ Poor\_\_\_\_\_

4. How would you describe your child’s overall development? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**V. CHILD’S HEALTH**

1. Name of your child’s Doctor or Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code (Area code) number

2. How long has your child been under this doctor’s care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Has your child had anything of the following illnesses?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Illness** | **Age** | **Fever? Yes or No** | **Duration in Days** | **Was child hospitalized?** |
| Chicken Pox |  |  |  |  |
| Diphtheria |  |  |  |  |
| Draining Ears |  |  |  |  |
| Ear Infections |  |  |  |  |
| Encephalitis |  |  |  |  |
| Epilepsy |  |  |  |  |
| Frequent Colds |  |  |  |  |
| Influenza |  |  |  |  |
| Measles |  |  |  |  |
| Meningitis |  |  |  |  |
| Mumps |  |  |  |  |
| Pneumonia |  |  |  |  |
| Polio |  |  |  |  |
| Scarlet Fever/Scarletina |  |  |  |  |
| Sinus Infection |  |  |  |  |
| Tonsillitis |  |  |  |  |
| Whooping Cough |  |  |  |  |
| Other |  |  |  |  |

4. Has your child experienced any high fevers? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

If yes, please explain briefly:

5. Has your child ever blacked out, been unconscious, or experience any seizures (convulsions)? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

If yes, please explain below (age of child, medications given, and any hospitalizations):

6. Please list any injuries or operations your child may have had. Please include tonsillectomy, adenoidectomy, or myringotomy (tubes in the ears), if applicable (Use back of this sheet if needed).

Injury/Operation Date Age

7. Does your child have any allergies? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, to what is he/she allergic?

8. Has your child previously taken or presently taking any medications? Yes\_\_\_\_ No\_\_\_\_

9. Does your child have any visual problems? Yes: \_\_\_\_\_ No: \_\_\_\_\_

10. Does your child wear glasses? Yes: \_\_\_\_\_ No: \_\_\_\_\_

11. Does your child have any physical handicaps? Yes: \_\_\_\_\_ No\_\_\_\_\_

If yes, please describe below:

12. In general, how would you describe your child’s health? Good\_\_\_\_ Fair\_\_\_\_ Poor\_\_\_\_

**VI. SCHOOL**

1. Is your child attending school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please give:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of School/Preschool Grade

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Classroom Teacher

2. Schools/Preschools previously attended (if any):

Name Address Dates Attended

3. Does your child attend any special education or remedial classes? Yes\_\_\_\_ No\_\_\_\_

If yes, please list:

Type of Class Dates Attended

4. What is your impression of your child’s learning abilities?

**VII. SPEECH AND LANGUAGE INFORMATION**

1. Please list your concerns about your child’s speech, language or hearing abilities. Please also list any changes you or others have observed:

2. When was this problem first noticed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Has your child been evaluated by any other agencies, specialists, or clinics? Yes\_\_\_ No\_\_

If yes, please provide the following information:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Agency Name** | **City/State** | **Date of Evaluation** | **Type of**  **Testing Completed** | **Results or Recommendations** |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |

Please use back of this sheet if needed.

4. Has your child received previous speech-language therapy? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please describe the focus of therapy (e.g., language articulation, etc.)

5. Is your child currently enrolled in speech-language therapy? Yes\_\_\_\_ No\_\_\_\_\_

If yes, please describe the focus of therapy and list the names of the speech-language pathologist:

**Early Language Milestones**

1. Please check the age at which your child performed the following actions (ages in months)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Action** | **4-6** | **7-9** | **10-12** | **13-18** | **19-24** | **25-36** | **37-48** | **49-60** |
| Gurgling Sounds |  |  |  |  |  |  |  |  |
| Babbling (bababa-dadada) |  |  |  |  |  |  |  |  |
| First Words |  |  |  |  |  |  |  |  |
| Two or more words together |  |  |  |  |  |  |  |  |
| Says his/her Name |  |  |  |  |  |  |  |  |
| Naming 10-20 Objects |  |  |  |  |  |  |  |  |
| Naming 10-20 Actions |  |  |  |  |  |  |  |  |
| Asks “What”, “Why” Questions |  |  |  |  |  |  |  |  |

**VII. EARLY LANGUAGE DEVELOPMENT**

***THIS SECTION IS INTENDED FOR CHILDREN LEARNING TO TALK (e.g., toddlers, and preschoolers). IF YOUR CHILD IS SCHOOL-AGED, PLEASE CONTINUE TO THE NEXT SECTION.***

1. At what age did you child say his/her first words? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What were your child’s first 5-10 words? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Did you child begin to babble or talk and stop? Yes\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please explain briefly here:

3. Approximately how many words did your child have at 18 months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At 24 Months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. At what age did your child begin using phrases and sentences? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please give some examples of first phrases and sentences:

Please give some examples of phrases/sentences your child is currently using:

5. How often does your child use verbal speech to talk with you?

Frequently\_\_\_\_\_\_\_\_ Sometimes\_\_\_\_\_\_\_\_ Rarely\_\_\_\_\_\_\_\_

6. How does your child make his/her needs known?

7. Does your child use many gestures? Please provide examples of gestures he/she uses:

8. Which does your child use the most? Phrases\_\_\_\_\_\_\_\_ Sentences\_\_\_\_\_\_\_\_

Once-to-two words\_\_\_\_\_\_\_\_ Sounds\_\_\_\_\_\_\_\_ Gestures\_\_\_\_\_\_\_\_

9. How well can your child be understood by the following persons? (Estimate percentage understood): Parents\_\_\_\_\_ Other Adults\_\_\_\_\_ Siblings\_\_\_\_\_ Peers/Friends\_\_\_\_\_

10. Is there anything else about your child’s communication skills that concern you?

Yes: \_\_\_\_\_\_ No: \_\_\_\_\_\_

If yes, please list your concerns here:

11. Have you or other family members tried to help your child overcome his/her communication problem? If so, what?

12. Has is helped? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

13. What do you think caused the problem?

14. Please list any additional comments/helpful hints for working with your child:

***\*\*PLEASE CONTINUE TO THE HEARING INFORMATION SECTION\*\****

**IX. LATER LANGUAGE DEVELOPMENT**

***THIS SECTION IS INTENDED FOR SCHOOL-AGED CHILDREN (e.g., elementary and middle school children). IF YOUR CHILD IS LEARNING TO TALK, PLEASE COMPLETE THE PREVIOUS SECTION.***

**Speech and Language Skills**

1. Please list your concerns about your child’s speech and/or language skills:

2. Does your child follow 2- and 3-step directions? Yes\_\_\_\_\_ No\_\_\_\_\_

a. Please give an example of directions your child routinely follows:

b. Does your child usually follow the steps in order? Yes\_\_\_\_\_ No\_\_\_\_\_

3. Does your child use compound and/or complex sentences? Yes\_\_\_\_ No\_\_\_\_\_

Please give an example of a sentence you have heard your child say recently:

4. Does your child understand and use words such as before/during/after, beside/below, or unless/until? Yes\_\_\_\_\_ No\_\_\_\_\_

5. Does your child use past, present, and future tense verbs? Yes\_\_\_\_\_ No\_\_\_\_\_

6. Can your child tell a story? Yes\_\_\_\_\_ No\_\_\_\_\_

7. Can your child have a conversation with other people? Yes\_\_\_\_\_ No\_\_\_\_\_

8. Does your child have trouble finding words or “get lost while talking?” Yes\_\_\_\_ No\_\_\_\_

**Reading, Writing, and Math Skills**

1. Is your child learning to read (i.e., in kindergarten, 1st, or 2nd grade)? Yes\_\_\_\_ No\_\_\_\_

*If yes, please answer the following:*

a. Can your child rhyme words? Yes\_\_\_\_\_ No\_\_\_\_\_

b. Does your child know the *SOUNDS* of the letters? Yes\_\_\_\_\_ No\_\_\_\_\_

c. Does your child enjoy reading/being read to? Yes\_\_\_\_\_ No\_\_\_\_

d. Do you think your child is having trouble learning to read? Yes\_\_\_\_ No\_\_\_\_

If yeas, please explain briefly here:

2. Is your child in 3rd grade or higher? Yes\_\_\_\_ No\_\_\_\_

*If yes, please answer the following*:

Do you think your child understands what he/she reads? Yes\_\_\_\_ No\_\_\_\_

Do you think your child reads as well as other children in the same class?

Yes\_\_\_\_\_ No\_\_\_\_\_

If no, please explain briefly here:

3. Can your child spell as well as other children in the same class? Yes\_\_\_\_\_ No\_\_\_\_\_

If no, please explain why you think your child has difficulty spelling:

4. Do you think your child writes stories/paragraphs as well as other children in the same class? Yes\_\_\_\_\_ No\_\_\_\_\_

**Play/Interaction Skills**

1. How does your child get along with other children his/her own age? (Please circle)

Good Fair Poor

2. Does your child have friends? Yes\_\_\_\_\_ No\_\_\_\_\_

If no, please explain why you think your child has difficulty making friends:

3. Does your child understand and tell jokes? Yes\_\_\_\_\_ No\_\_\_\_\_

**X. HEARING INFORMATION**

1. Do you think your child has trouble hearing? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please explain briefly

2. Has your child had any ear infections/aches Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please give the date of the most recent, which ear and severity:

3. Has your child ever had any ear drainage? Yes\_\_\_\_\_ No\_\_\_\_\_

4. Has your child ever been exposed to a loud noise or explosion? Yes\_\_\_\_\_ No\_\_\_\_\_

5. Does your child ever complain of fullness/pressure or noises (e.g., ringing, buzzing) in the ear?

Yes\_\_\_\_\_\_ No\_\_\_\_\_

If yes, please explain below:

6. Do you think your child’s hearing varies from day-to-day? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please explain and list the conditions under which it varies:

7. Can your child tell the direction of sound/noises? Yes\_\_\_\_\_ No\_\_\_\_\_

8. Does your child watch the speaker’s face? Yes\_\_\_\_\_ No\_\_\_\_\_

9. Please list any other concerns you may have about your child’s hearing:

Please use this space to add any additional information or list any concerns that were not already covered in this information form: