Boston Children's Hospital
Until every child is well™

Department of Otolaryngology and Communication Enhancement
Speech-Language Pathology Program
www.childrenshospital.org

Please complete this form in its entirety. Once completed, return it by mail or fax to the Boston Children's Hospital site that is preferable to you.

- Lexington:482 Bedford St, Lexington MA 02420, fax: 781-216-2900, phone: 781-216-2999
- Peabody: 10 Centennial Dr, Peabody MA 01960, fax: 781-216-3597, phone: 781-216-3400
- Waltham: 9 Hope Ave, Waltham MA 02453, fax: 781-216-2252, phone: 781-216-2237

Speech and Language Evaluation Intake Questionnaire

Child's Name:	Date of Birth:		
Home Address (Street, Town, State):			
Referred By:			
If referred by the school, is the school paying for the evaluation?		Yes	No
Questionnaire Completed By:	Phone #:		

STATE SPECIFIC CONCERNS & QUESTIONS for this Evaluation: (**Required to secure appointment.**)

What is the child's primary language?		
Are there any other languages spoken within the home? If yes, please list:	Yes	No
Would you like an interpreter for the evaluation?	Yes	No

FAMILY INFORMATION/HISTORY

People currently living within the household:

1.	Age:
2.	Age:
3.	Age:
4.	Age:
5.	Age:

Do any immediate or extended family members have a history of:		
Language Disorders?	Yes	No
Articulation Disorders?	Yes	No
Learning Disabilities?	Yes	No
Motor Disorders?	Yes	No
Fluency/Stuttering Problems?	Yes	No
If YES to any above, please describe:		

MEDICAL INFORMATION

Was the pregnancy full term? If no, how long?	Yes	No
Were there any complications during pregnancy or delivery? If yes, please explain:	Yes	No
Were there any medical problems detected at birth? If yes, please describe:	Yes	No
Did your child require a stay in the NICU?	Yes	No

Has your child had any serious illnesses, injuries or hospitalizations? If yes, please describe:	Yes	No

Does your child have any developmental or medical diagnoses? If yes, please list:	Yes	No
Does your child currently take any medications? If yes, please list:	Yes	No
Is your child followed by any other departments at Boston Children's Hospital or other hospitals in the area? If yes, please list:	Yes	No

HEARING STATUS

Does your child have a history of ear infection or middle ear fluid?	Yes	No
If yes, was your child treated with antibiotics?	Yes	No
Ear Tubes?	Yes	No
When/Where were tubes placed?		

Has your child's hearing been tested by an audiologist?	Yes	No
If yes, where: Date: Results: **<u>If no</u>, an audiological evaluation must be completed before a speech-language evaluation. To schedule at Boston Children's Hospital, call (617) 355-6461.**		

FEEDING HISTORY

Did your child have any difficulty with feeding (e.g., choking with liquids, difficulty managing solids, trouble transitioning to textures, poor weight gain, reflux, etc.)? If yes, please list:	Yes	No

Is your child particularly selective about the foods he/she will eat (more so than other children the same age)?	Yes	No

Other Medical

Is there anything else we should know about your child's medical history or current medical status? Please describe here.

DEVELOPMENTAL HISTORY

Please list the ages your child achieved the following developmental milestones:

Skill	Age achieved
Sat independently	
Crawled	
Walked independently	
Babbled	
Said first words	
Combined two words	
Produced sentences	

Did your child ever stop talking or stop saying words s/he used to say?	Yes	No
If yes, please explain:		

CURRENT COMMUNICATION SKILLS

Currently does your child:

Respond to his/her name?	Yes	No	Sometimes
Point to objects when asked?	Yes	No	Sometimes/Some
Follow simple directions?	Yes	No	Sometimes/Some
Get objects from another room when asked?	Yes	No	Sometimes/Some
Point to body parts when asked?	Yes	No	Sometimes/Some
Point to pictures in books when asked?	Yes	No	Sometimes/Some
Answer simple questions?	Yes	No	Sometimes/Some
Point to family members when asked?	Yes	No	Sometimes/Some
Understand prepositions (e.g., in, on, under, next to)?	Yes	No	Sometimes/Some
Understand color and size words (e.g., red, big, small)?	Yes	No	Sometimes/Some
Engage in pretend/imaginary play?	Yes	No	Sometimes

Please circle the phrases that describe how your child communicates (circle all that apply)

Pointing, other gestures	Simple 3-4 word phrases
Babbling	Sentences with some errors
Manual signs	Grammatically correct sentences
Single words	Tells stories, explains what happened
Two-word combinations	

Other/Related:

Does your child ignore you when you are speaking? If yes, please describe:	Yes	No	Sometimes

Does your child socialize/play with other children?	Yes	No	Sometimes

Do you or others have difficulty understanding your child's speech?	Yes	No	Sometimes

Does your child appear frustrated when he/she is not understood?	Yes	No	Sometimes

Does your child repeat sounds or words when speaking?	Yes	No	Sometimes

PREVIOUS EVALUATIONS

Please list below what types of evaluations the child has had (e.g., speech and language, early intervention, developmental assessments, reading, neuropsychological, etc.).

Type of Evaluation	Where	Date

Please send in/bring copies of relevant evaluation reports.

EDUCATIONAL INFORMATION

Please bring/send a copy of current IEP and recent IEP Progress Report.

Does your child go to daycare, preschool, school?	Yes	No
What level/grade is your child in?		
What type of classroom? (e.g., regular education, integrated, substantially separate)		

Does your child receive any specialized services? If yes, please list the frequency of each service:	Yes	No

Early Intervention	
Speech-language therapy	
Occupational therapy	
Physical therapy	
Resource Room Support	
Special Education	
Aide/Paraprofessional	
Reading	
Behavioral	
Other	

Are these services provided through the school? If no, please list facility:	Yes	No

Do have concerns about your child's reading or academic progress? If yes, please explain:	Yes	No

What are your child's favorite/preferred activities and toys?

Please tell us anything else that may help us to better understand your child.