



Carolina Pediatric Dysphagia

Pediatric Dysphagia and Oral Myofunctional Disorders
Joan D. Comrie and Associates
(919) 877-9800

Speech/Language Evaluation Questionnaire

Please answer all questions that apply to your child

Patient Name _____ Date of Birth _____ Date of Evaluation _____

Parent/Guardian Names: _____

Pediatrician: _____ Pediatric Group: _____

What, if any, diagnosis does your child have? _____

Chief Speech/Language Concerns _____

What are your goals for this evaluation? _____

Is your child allergic to latex? Yes ___ No ___

Prenatal/Birth History:

Was your child born full term? Yes ___ No ___; If no, how many weeks gestation? _____

Was your child in the NICU? Yes ___ No ___; If yes, why and for how long? _____

Developmental/Sensory Processing History:

Does your child attend day care or school? _____

When did your child sit unassisted _____ crawl _____ walk _____?

Is your child currently receiving any other therapies? _____ If yes, please list: _____

Does your child have a visual impairment? Yes ___ No ___ auditory impairment? Yes ___ No ___

Did your child pass his/her most recent hearing screening Yes ___ No ___, Date of screening? _____

Do you have any concerns about your child's hearing? Please explain. _____

Does your child sleep through the night? Yes ___ No ___ Is s/he able to maintain eye contact? Yes ___ No ___

Does your child like to swing? Yes ___ No ___ Does your child seek rough play? Yes ___ No ___

Does your child enjoy playing in a sandbox? Yes ___ No ___ Is your child sensitive to certain fabric make? Yes ___

No ___ Will your child tolerate being messy or having their hands messy? Yes ___ No ___

Will your child play, crawl, walk, or sit in grass? Yes ___ No ___

General Medical History:

Has your child ever been hospitalized? _____; If yes, why? _____

Please list any medications your child is currently taking and the dosage per day: _____

Has your child had any problems with his/her tonsils or adenoids? ____ If yes, please explain: _____

Does your child do any of the following (check all that apply): snore ____; audibly breathe at rest ____; drool ____; audibly breathe during activity ____; audibly breathe while sleeping ____; have an open mouth posture ____

Is there a history of high fevers or seizures? Yes ____ No ____

Does your child have a history of ear infections? Yes ____ No ____ If yes, when and how were they treated?

When was your child's last hearing assessment? _____ What were the results? Pass ____ Fail ____

Allergies and Food Intolerances:

Does your child have a diagnosis of food, medication, or environmental allergies? Yes ____ No ____

Has your child ever had allergy testing? Yes ____ No ____; If yes, type of test and results: _____

If no, do you suspect any allergies? Yes ____ No ____; If yes, please list: _____

Does anyone in your family have allergies or food intolerances? Yes ____ No ____; If yes, please list relationship to child and what they are allergic to: _____

Feeding History:

Do you have any concerns regarding issues related to feeding or swallowing? Yes ____ No ____

How is your child currently fed? Breast ____; Bottle ____; NG Tube ____; G-Tube ____; Puree ____; Solids ____
Other _____

Does your child currently drink from a bottle ____; sippy cup ____; cup with straw ____; open cup ____?

Does your child choke ____; cough ____; gag ____; vomit during feeding ____?

Oral Motor History:

How many teeth does your child have? _____ Is tooth brushing stressful? Yes ____ No ____

Has your child ever had any major dental work completed? Yes ____ No ____

Did your child mouth objects as an infant? Yes ____ No ____ Does your child mouth objects? Yes ____ No ____

Does your child take a pacifier? Yes ____ No ____, if no did she/he? _____

Does your child suck her/his thumb? Yes ____ No ____ if no did she/he? _____

Speech/Language History:

Does your child speak any other languages? Yes ____ No ____

Has your child received speech/language services in the past? Yes ____ No ____ If so, when and for how long?

Do you have any other children? Yes ____ No ____ If so, what are their names and ages?

Does your child have opportunities to interact with children outside of the household? Yes ____ No ____

Is there any family history of speech and/or language delays? Yes _____ No _____

If so, please describe relationship to child, treatment implemented, and duration of services:

Do you have any concerns regarding: Stuttering—Yes _____ No _____, Voice Quality—Yes _____ No _____,
Volume—Yes _____ No _____

When did your child say his/her first word? _____ What was your child's first word? _____

Approximately how many words does your child currently use? _____ Examples: _____

Does your child use 2+ words together? Yes _____ No _____ Examples: _____

Does your child seem to understand you? Yes _____ No _____ Others? Yes _____ No _____

On a scale of 1-10 (1: not at all, 10: 100% of the time): How well do you understand your child? _____

How well do others understand your child? _____

Does your child look at the speaker's face? Yes _____ No _____

What sounds does your child use? (Circle all that apply) P M H N W B K G D T S Z F V

What is your child's main form of communication? Words _____; Gestures _____; Signs _____; Body Language _____;

Grunting _____; Vocalizing _____; Other: _____

How does your child express his/her wants and needs? _____

Does your child follow simple commands? Yes _____ No _____ 2-step commands? Yes _____ No _____

Does your child ask questions? Yes _____ No _____ Does your child imitate new words? Yes _____ No _____