ROCHESTER HEARING AND SPEECH CENTER
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3199 W. Ridge Road Rochester, NY 14626 (585) 723-2140
1170 Ridge Road Webster, NY 14580 (585) 872-8073

SCHOOL AGE QUESTIONNAIRE

Date:_____ Name of Person completing this form:_____

Information about the child: **Please complete as much as possible.**

Client's Name:_____
(Last) (First) (M.I.) (nickname)

Age:_____ Birthdate:_____ Sex: M_____F_____

STATEMENT OF THE PROBLEM:

1. Please state in your own words any concerns you have about the child's speech and language and/or hearing: _____

2. Family history of speech, hearing or learning problems? (check) _____ Yes _____ No
If yes, please explain: _____

3. Is there a language other than English spoken in the home on a regular basis? (This includes American Sign Language.) If yes, please describe and state how often used.

4. What do you hope can be achieved through this evaluation?

SPEECH AND LANGUAGE INFORMATION:

3. Please check all statements that apply to the child.
   - ____ I think the child's speech and language are all right for his/her age.
   - ____ The child does not seem to understand spoken instructions.
   - ____ S/he only understands when others show what is wanted.
   - ____ The child has not yet started to talk.
   - ____ S/he talks a little, but not as much as other children the same age.
   - ____ S/he can't explain what s/he wants very well.
   - ____ S/he is difficult to understand.
   - ____ S/he mispronounces sounds or words.
   - ____ S/he often hesitates, holds on to, or repeats sounds or words.
   - ____ Child's voice is nasal/harsh/too loud.

HEARING:

1. Has your child's hearing been tested? _____ Yes _____ No
   If yes, when was the testing done, who did it, and what were the results?
   When:_____ Who:_____
   Results:_____

2. Does your child's hearing seems better in the : ____ left ear ____ right ear ____ both the same

3. Check all statements which apply to the child's hearing:
   ____ Has no difficulty hearing
   ____ Child doesn't always answer when called from another room
   ____ Doesn't always look to find sounds such as a telephone, siren, doorbell, or voice
   ____ Child hears a loud voice much better
   ____ Can hear better if the child watches your face
   ____ Insists on having the TV turned up loud
   ____ Child's teacher says that s/he has trouble following verbal directions
   ____ Child frequently says "Huh?" or "What?"
   ____ Child wears a hearing aid

BIRTH INFORMATION:

1. Describe mother's general health during pregnancy _____
   _____
   _____

2. Describe mother's illnesses, accidents, or difficulties during pregnancy: _____
   _____
   _____

3. Medications/alcohol/drugs used during pregnancy, please describe:_____
   _____
   _____

4. How long was the pregnancy? _____ Baby's birth weight:_____

5. Did the child/mother experience any of the following during labor and delivery or after delivery? (Check all that apply.)

____	difficult/long labor	____	Rh problems
____	Caesarean section	____	seizures
____	evidence of birth injury	____	jaundice (yellowish skin color)
____	birth defects	____	cyanosis (bluish skin color)
____	difficulty breathing	____	infection
____	intensive care nursery	____	Other _____

How was this taken care of?_____
_____

DEVELOPMENTAL HISTORY:

1. Overall development seems to be:
   ____ somewhat faster than most children. In what areas? _____
   _____
   ____ about the same as most children
   ____ somewhat slower than most children. In what areas?_____
   _____

2. Which of the following describe the child's coordination? Check all that apply:
   ____ Has no difficulty with general coordination
   ____ Has difficulty getting on/off chairs or vehicle toys
   ____ Frequently stumbles when walking or jumping
   ____ Has difficulty maintaining balance when sitting, walking, jumping or bending over (underline area of difficulty)
   ____ Has trouble catching and throwing a ball
   ____ Seems clumsier than most children
   ____ Has difficulty working with small objects such as puzzles
   ____ Other concerns (please describe)
   _____
   _____

BEHAVIOR

1. The child has problems in these areas: (check all statements that apply)

   ____ Frequent temper tantrums
   ____ Does not interact easily with others
   ____ Often fights with other children
   ____ Unusually high activity level
   ____ Difficulty concentrating or staying with one activity
   ____ Impulsive
   ____ Often breaks or destroys things
   ____ Easily frustrated
   ____ Short attention span
   ____ Other: _____

MEDICAL INFORMATION

GENERAL HEALTH

1. Describe general health of the child: _____
2. What medication(s) is the child presently taking? _____
   _____ For how long? _____

3. Has the child had any of the following? (Check all statements that apply)

Check	Age		Check	Age	
____	____	failure to thrive	____	____	chicken pox
____	____	mumps	____	____	high fever
____	____	scarlet fever	____	____	seizures
____	____	measles -10 or 3 days	____	____	frequent colds
____	____	pneumonia	____	____	tonsils removed
____	____	meningitis	____	____	adenoids removed
____	____	head injuries	____	____	operations
____	____	allergies	____	____	Other:_____
____	____	asthma			

Please explain: _____

_____

EARS:

1. How many ear infections has the child had? ____ When was the first? _____
   Most recent?_____ What type of treatment was given? _____

2. Check any problems with the child's ears, past and present:
   ____ fluid present in ears. When? _____
   ____ excessive wax
   ____ drainage from ears
   ____ tubes in ears; when inserted? _____ By which doctor? _____
   ____ other:_____

VISION:

1. Are there concerns about the child's sight? _____
2. Has vision been tested? _____ Where? _____
   When? _____ Results? _____

DENTAL HEALTH:

1. Are there concerns about the child's teeth or mouth? _____
   Describe: _____
2. Dentist's name:_____

EDUCATIONAL INFORMATION:

1. Present School: _____ Grade?_____
   School District:_____
2. Has the child repeated any grades? ____ Yes ____ No Which one(s)?_____
3. How well does the child do in school? ____ good ____average____ below average ____ poor
4. If the child is not doing well in school, please describe:_____

   _____

SPECIAL SERVICES

Describe any special testing, treatment or therapy the child has had in the past or is currently receiving. (Examples: speech, psychological, developmental, neurological)

I. Evaluations

A. Previous testing completed:

Facility/Location: _____ Date: _____

Results: _____

B. Previous testing completed:

Facility/Location: _____ Date: _____

Results: _____

II. Therapy

A. Services received/receiving: _____

Facility/Location: _____ Date: _____

Frequency_____

Type of therapy (1:1 or group size) _____

B. Services received/receiving: _____

Facility/Location: _____ Date: _____

Frequency_____

Type of therapy (1:1 or group size) _____

III. Present Classroom Information

Teacher's name: _____

Class size: _____

Class modification: _____

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PERSONS LIVING IN HOUSEHOLD:

	NAME	AGE	RELATIONSHIP TO CHILD
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Father's Name: _____ Date of Birth: _____
Last *First*

Home Phone: ( ) _____ Work Phone: ( ) _____

Current Marital Status: ___ Single ___ Married ___ Separated

Education Level Completed: ___ High School/GED ___ College Graduate ___ Other _____

Mother's Name: _____ Date of Birth: _____
Last *First*

Home Phone: ( ) _____ Work Phone: ( ) _____

Current Marital Status: ___ Single ___ Married ___ Separated

Education Level Completed: ___ High School/GED ___ College Graduate ___ Other _____

PLEASE SIGN ATTACHED CONSENT TO TREAT FORM