Merritt Speech & Learning

"The proper diagnosis is critical to remediation."

Questionnaire - Adult

Speech, Language or Learning Disabilities

Date_____

Name_____

Age_____ Birth date_____ Sex M____ F_____

Address_____

City_____ State_____ Zip_____

Phone_____ Cell Phone_____

Person completing form_____

Relationship to client_____

Name of referring Doctor, Agency, or Friend

_____

Their specialty_____

Address_____

Phone_____

Have you had any previous testing either at school or through a private agency?_____

If so, give the name of the agency and the dates tested:

Name_____ Date_____

Address_____

Why is this evaluation being requested?

Do other family members have similar problems?_____

Explain:

FAMILY INFORMATION

SPOUSE:

Name_____ Age_____

Address[same] _____

Phone_____ Cell Phone_____

Occupation_____

Business Phone_____

Employer_____

Health: ☐Good ☐Fair ☐Poor

Education completed:_____

BIRTH HISTORY

Weight of child at birth_____ Were you full term?_____

Were there any unusual factors relating to the pregnancy (such as toxemia, x-ray treatments, RH negative, German measles, other illnesses, drugs or medication)?_____

Type of birth:

☐normal ☐induced ☐forceps ☐Caesarean

☐breech ☐premature ☐unknown ☐adopted

DEVELOPMENTAL HISTORY

In early childhood, did you have any feeding problems, such as poor control of sucking, food allergies, digestive problems, etc? ___Yes ___No

Describe:

Do you feel that you were late or had difficulty in the development of the

following behaviors: ____Yes ____No

Sitting	____Yes ____No
Walking	____Yes ____No
Eating solid foods	____Yes ____No
Self-feeding	____Yes ____No
Crawling	____Yes ____No
Self-dressing	____Yes ____No
Standing alone	____Yes ____No
Bladder and bowel control	____Yes ____No

Which hand do you prefer?_____

Do you have any present problems in eating or sleeping?_____

Do you have any nervous habits?_____

How would you describe yourself?

Do you believe that you are well coordinated in walking, using your hands, running, riding, etc.? __Yes __No

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MEDICAL FACTORS

Present Weight_____ Present Height_____

Doctor most familiar with you_____

Doctor's phone number_____

When you were a child, did you have any of these childhood diseases:

Measles	____Yes ____No
Rheumatic Fever	____Yes ____No
Mumps	____Yes ____No
Chicken Pox	____Yes ____No
Whooping Cough	____Yes ____No
Pneumonia	____Yes ____No
Other	_____

Current medications:_____

Frequent colds, frequent sore throats?_____

Allergies, asthma, hay fever, etc?_____

Do you tend to breathe with your mouth open?_____

Have you had any operations?_____ Specify:_____

Have tonsils and adenoids been removed?_____ When?_____

Have you had any trouble with your ears, such as earaches, infections, evidence of hearing loss?_____

Has your hearing been tested?_____When_____

Have your eyes been screened?_____ When_____

Have you ever worn glasses or had any difficulty with your eyes?_____
Specify:_____

Optometrist_____ Phone_____

Have you ever had a concussion? ____Yes ____No

If yes, details:

EDUCATION

Education Level _____ Name of School_____

Did you like school?_____ Why?_____

Were/are any school subjects difficult for you?_____

Did you ever fail or skip a grade?_____

What were your best subjects?_____

Did you attend special classes?_____
(e.g. speech therapy, language development, reading clinic, etc.)

What was your behavior like in school?

__ poor work habits
__ did not pay attention
__ did not listen
__ did not use time and materials effectively
__ written work careless
__ does not discipline yourself

other_____

What kind of grades did you receive?

__A's
__A's & B's
__B's
__B's & C's
__C's
__C's & D's
__D's
__D's & F's
__F's
__Inconsistent grades, Describe:

_____

What type of study habits did you demonstrate?

_____

What are your two favorite past times?

_____

List the names of schools attended in the last 5 years:

OCUPATION

How old were you when you first started to work?_____

Where do you work?_____

Address_____

What kind of work would you like to do?_____

List the jobs that you have had in the last five years:

LANGUAGE DEVELOPMENT

How old were you when you first started to use words?_____

How old were you when you first made sentences?_____

Do you have a speech problem?_____

Describe:_____

When did you first notice it?_____

If no speech problem now, did you ever have one?_____

Describe:_____

Have you had any help for this difficulty?_____

Place_____

Dates_____

Has your speech noticeably changed in the last six months?_____

What do you believe is the main cause of your speech/language difficulty?

Is any language other than English spoken in the home?_____

What language?_____

I give my permission to be tested:

X _____

Do you want a copy of this report sent to any one?_____

Who?_____

_____

BILLING INFORMATION

Who is responsible for the bill?

Name_____

Phone Number_____

Address_____

Employer_____

Business Address_____

Business Phone _____

Occupation_____

Insurance forms will be filled out if you provide the form. However, please note that we do not accept assignment and you, NOT THE INSURANCE COMPANY, will be responsible for the charges.

Evaluation fees are payable at the time of the testing unless advance arrangements have been made with this office.

DIRECTIONS TO OUR OFFICE

Merritt Speech & Learning, Inc.
1309-110 St. Johns Bluff Road North
Jacksonville, FL 32225

Phone: 904-721-4122 Fax: 904-721-4112

Email: dana@merrittspeech.com

We are located 0.3 miles from Monument Rd.
or
1.3 miles from Atlantic Blvd.

at 1309 St. Johns Bluff Rd N.
Building B
Come inside and we are Suite 110