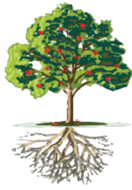


Merritt Speech & Learning

"The proper diagnosis is critical to remediation."

Questionnaire - Child or Adolescent

Speech, Language or Learning Disabilities

Date__________________

Name____

Age_____ Birth date___________ Sex M____ F____

Address____

City_____________________________ State_________ Zip___________________

Phone_______________________________

Person completing form____

Relationship to client____

Name of referring Doctor, Agency, or friend:

____

Their specialty____

Address____

Phone_______________________________

Has the child 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

FATHER:

Father's Name____ Age______

Address [same] or____

Phone_________________________ Email____

Cell Phone_________________________

Occupation____

Business Phone_________________________

Employer____

Health: _____Good _____Fair _____Poor

Education completed:____

MOTHER:

Mother's Name____ Age______

Address [same] or____

Phone_________________________ Email____

Cell Phone_________________________

Occupation____

Business Phone___________________________

Employer____

Health: _____Good _____Fair _____Poor

Education completed:____

List all children in the family from the oldest to the youngest:

Name____ Age_____ Health____________

Name____ Age_____ Health_____________

Name____ Age_____ Health_____________

Name____ Age_____ Health_____________

Name____ Age_____ Health_____________

Name____ Age_____ Health_____________

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

What language?____

What is your nationality?____

BIRTH HISTORY

Weight of child at birth____________ Was child 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 the child have any feeding problems, such as poor control of sucking, swallowing, food allergies, stomach problems etc?

____Yes ____No

Describe:

Do you feel the child was late or had difficulty in the development of any 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 does the child prefer?____

Does the child have any present problems in eating or sleeping?_______________

Does he/she have any nervous habits?

____

How would you describe your child?

Do you believe that your child is now well coordinated in walking, using his hands, running, riding a tricycle or bike, etc.? ____Yes ____No

Explain:____

MEDICAL FACTORS

Present weight_______________ Present height_____________________

Doctor most familiar with child____

Doctor's phone number____

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?____

Does he tend to breathe with his mouth open?_______________________________

Has the child had any operations?_____ Specify: ______________________________

Have tonsils and adenoids been removed?_____ When?________________________

Has he had any trouble with his ears, such as earaches, infections, evidence of hearing loss?____

Has hearing been tested?______________ When_______________________________

Have his/her eyes been screened?______ When_______________________________

Has he/she ever worn glasses or had any difficulty with his eyes?_____________

Explain:____

Optometrist_____________________________________ Phone____________________

Has your child ever had a concussion? _____Yes _____No

If yes, details:

EDUCATION

Present grade______ Name of School____

Teacher's name____

Does he/she like school?________

Does he/she like his teacher?________

Are any school subjects difficult for him/her?________________________________

Has he/she ever failed or skipped a grade?__________________________________

What are his/her best subjects?____

Have you ever discussed the problems with his/her teacher?__________________

Does he attend special classes?____
(e.g. speech therapy, language development, reading clinic, etc.)

How does the teacher describe your child's behavior in school?

____ poor work habits
____ does not pay attention
____ does not listen
____ does not use time and materials effectively
____ written work careless
____ talks too much
____ disruptive
____ lonely
____ does not discipline himself
other____

What kind of grades does your child 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 does your child demonstrate?

____

What are your child's two favorite past times?

____

List the schools attended in the last 5 years:

LANGUAGE DEVELOPMENT

How old was the child when he/she first started to use words?________________

How old was the child when he/she first made sentences?_____________________

Does he/she have a speech problem?____________________________________

Describe:____

When did you first notice it?____

If no speech problem now, did he/she ever have one?________________________

Describe:____

Has the child had any help for this difficulty?________________________________

Place____

Dates____

Has speech noticeably changed in the last six months?_______________________

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

I give my permission for my child 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

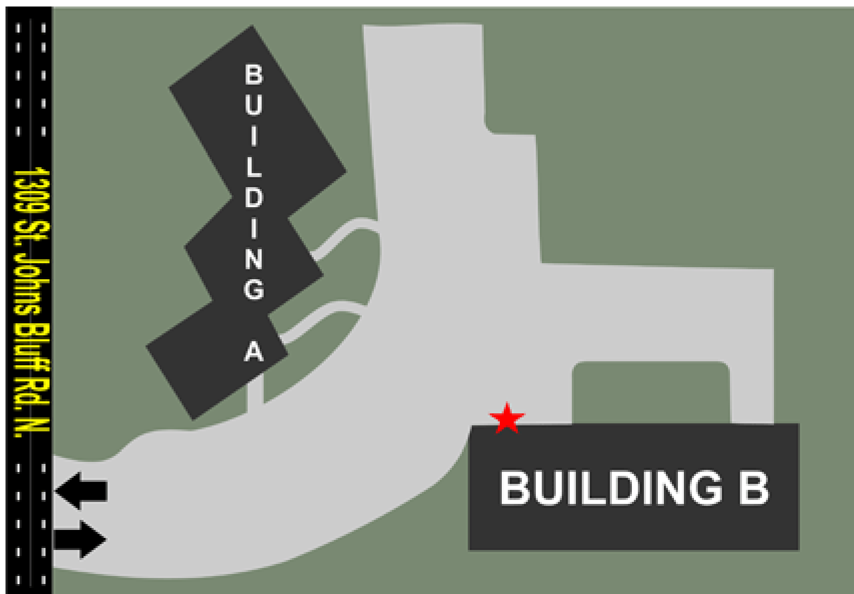
Merritt Speech & Learning
1309-110 St. Johns Bluff Road North
Jacksonville, FL 32225

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



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