

DEVELOPMENTAL QUESTIONNAIRE

Child's Name: _____ Gender: M / F Date of Birth: _____
(First) (Last)

Handedness (Circle one): Right / Left / Both Current Grade in school: _____ School name: _____

Ethnicity (Circle one): *White Black Hispanic/Latino Asian American Indian Hawaiian or Alaskan Native*

Address: _____

Telephone: _____ Email: _____

DEVELOPMENTAL HISTORY (Please CIRCLE Yes/No and provide information where requested)

1. Does your child have any developmental disabilities (e.g., autism, mental retardation)? Yes No
2. Does your child have any current or previous diagnosis of hearing problems? Yes No
If yes, please describe _____
Does your child wear a hearing aid? Yes No

Does your child have ear infections? (Circle one): Never Occasionally Frequently
Does your child have tubes placed in his/her ear right now Yes No Right / Left / Both ears
Has your child had tubes places in his/her ears in the past Yes No Right / Left / Both ears
3. Does your child have any vision problems? Yes No
If yes, please describe _____
4. Does your child have a history of serious health problems? Yes No
(e.g., seizures, other neurological disorders)?
If yes, please describe _____
5. Does your child have a history of any motor impairment/delay? Yes No
(e.g., delayed walking, movement disorders etc.) If yes, please describe _____
6. Has your child been diagnosed with any psychological conditions (e.g., ADHD, anxiety, mood disorders, depression)?
Yes No
If yes, please describe _____ Is he/she on medication? Yes No
Name of medication (s) _____
7. Has your child ever been diagnosed/received therapy for speech problems (i.e. saying his/her speech sounds)? Yes No
If yes, please describe _____
8. Was your child a late talker? Yes No Age of: first words _____ two words utterances _____
9. Has your child ever been diagnosed with language problems (e.g., difficulty understanding what he/she hears, following directions, expressing himself/herself so others can follow)? Yes No
If yes, describe _____
10. Has your child ever received therapy for language problems in the past (i.e. difficulty understanding what he/she hears, following directions, expressing himself/herself so others can follow)? Yes No
If yes, please mention at what age and for how long _____
11. Do you have any concerns about your child's listening abilities or spoken language understanding **right now**? Yes No
For example, child needs instructions to be repeated (50% or more of the time), says "huh?", "what?" five or more times a day, easily forgets or misunderstands what is said, understands fewer words than expected for his/her age etc.
If yes, please describe _____

12. Does your child get easily distracted by background sounds or have difficulty listening in noisy situations? Yes No
13. Do you have any concerns about your child's spoken language abilities right now? Yes No
If yes, please describe _____
14. Does your child get speech or language therapy right now in school or somewhere else?
Speech (saying speech sounds): Yes No Language: Yes No
15. Does your child have difficulty remembering/recalling information (e.g., what was heard/seen a day/week/month earlier)?
Yes No
If yes, please describe _____
16. Does your child get easily distracted from completing a given task (50% or more of the time) Yes No
17. Does your child demonstrate below grade-level performance in one or more academic areas? Yes No
If yes, please specify areas _____
18. Does your child repeatedly show a lack of motivation to learn? Yes No
19. Does your child receive any kind of help at school? Yes No
If yes, what kind? _____
20. Where did you hear about this project? _____

HEARING/USING ANOTHER LANGUAGE

Does your child hear/use any other language than English? Yes No If yes, what language _____
Which languages are spoken in the home? _____

Is your child being taught any languages other than English in school or somewhere else? Yes No
Which language(s)? _____

How well does your child speak the other language? (circle one): *Some words* *Simple phrases* *Full conversations*
Mark how much your child uses the other language for conversation, NOT for any school reason

Amount of time your child speaks another language each day. Check all that apply

	0 min	30min	1 hour	2 hours	3 hours	More than 3 hours
At home						
At school						
During after school activities						

FAMILY HISTORY

Does anyone else in the child's family have problems in speech, language, hearing, or learning? Yes No
If yes, please describe problem _____ Relation to child _____

Does anyone else in the child's family have reading problems? Yes No
If yes, please describe problem _____ Relation to child _____

PARENT/CAREGIVER HIGHEST EDUCATION COMPLETED (Circle one)

Mother: Completed: Less than high school High School College (4 year) Associate degree Master's Doctorate
Father: Completed: Less than high school High School College (4 year) Associate degree Master's Doctorate

ANNUAL FAMILY INCOME (Circle one)

≤ \$30,000 \$31,000 to \$40,000 \$41,000 to \$69,000 \$70,000 to \$100,000 >\$100,000

NAME OF PARENT/CAREGIVER FILLING OUT THIS FORM _____ DATE _____