Patient's Name:

UCLA Health System

UCLA Speech Clinic Child Communication Questionnaire

Please fill out this form completely, as we rely heavily on the information provided to adequately evaluate your child's speech and language abilities. If a question does not apply or you do not know the answer, please mark with N/A. Thank you!

Reason for Visit:

In the area of speech and/or language, my child has difficulty with:

____

____

Medical History:

Has your child had (or does your child currently have) any of the following:

- ☐ Adenoidectomy
- ☐ Allergies
- ☐ Breathing difficulties
- ☐ Ear infections
- ☐ Head injury
- ☐ Hearing loss
- ☐ Seizures/spasms
- ☐ Tonsillectomy
- ☐ Vision problems
- ☐ Premature birth
- ☐ Complications at birth
- ☐ History of thumb sucking or use of pacifier
- ☐ Difficulties with breastfeeding
- ☐ Major illnesses/injuries/surgeries/ other medical conditions:

____

____

Does your child currently have any pain in the mouth or throat region? YES NO

Did your child pass a newborn hearing screening? YES NO

Has your child had a recent hearing test? YES NO

When? _________________________

Where? _________________________

Results: ____

What language(s) is/are spoken in the home? ____

What percent of exposure in English? _______%

What percent of exposure in another language? _______%

What is your child's primary language? ____

Developmental History:

What is the approximate age that your child achieved the following developmental milestones?

___________ first words (e.g., mama, bye-bye, dada)

___________ two words together (e.g., "more juice," "bye mama")

___________ began walking

Home:

Who lives at home with your child? (Please include age of siblings, if any):

____

Is there a family history of speech, language, or academic problems (e.g., speech delay, stuttering, autism, learning disability)? If so, please describe: ____

How many hours per day is your child in front of a screen (i.e. smart phone, tablet, television)?

Number of minutes/hours: _______

Describe use, i.e. ipad, smart phone, television, etc.: ____________

How often does your child interact with other same-aged peers? Are there any concerns about social interaction?

____

____

School:

Is your child currently attending school/preschool/day care? YES NO

If so, where? _______________________________________

How many hours per day/week? ________________________

Are there any current academic or behavioral concerns? If so, please describe:

____

____

____

Previous or Current Services:

Is your child currently receiving any therapies, or has he/she received any therapy in the past?

Type of therapy	# of sessions per week	When did therapy begin/end?
____________________	_________________	_________________________
____________________	_________________	_________________________
____________________	_________________	_________________________

Current Speech and Language Information:

Does your child…

Retrieve/point to common objects upon request (e.g., ball, cup, shoe)?	YES	NO
Appear to understand what you are saying?	YES	NO
Follow simple directions (e.g., “get your shoes”)?	YES	NO

Any other concerns with following directions, understanding, comprehension?

____

How does your child primarily communicate (e.g. body language, gestures, sounds, words, phrases, sentences)?

____

How many words would you estimate your child uses now? _________________

I can understand my child ________% of the time.

Other people can understand my child approximately ________% of the time

Is there anything else you would like to tell us about your child?

____

____

____

Please bring this completed form up to the front desk. Thank you!