The Speech Pathology Group

Walnut Creek/Main Clinic Office:
2021 Ygnacio Valley Road, Suite C-202
Walnut Creek, CA 94598

East County Clinic:
300 East Leland Road, Suite 100
Pittsburg, CA 94556

Berkeley Clinic:
3021 Telegraph Avenue, Suite D
Berkeley, CA 94705

DIAGNOSTIC QUESTIONNAIRE

Identification:

Child's Name ____________________________________ Birth Date ____________ Age __________

Home Address ____
Street City State Zip

Referred by: _______________________________ Relationship to Child: _______________________

Person Completing Form: __________________________Relationship to Child: __________________

Contact Information:

Family Address: ____
(Where child resides) Street# City Zip

Family Email Address: ____

Telephone Numbers _________________________ ______________________________________
Home Phone Cell Phone(s)

Mother's Name: ____________________________________ Mother's Occupation: _______________

Address and Ph # ___________________________________Work Phone: _______________________
(If different than child's)

Father's Name: _____________________________________ Father's Occupation: _______________

Address and Ph # ___________________________________ Work Phone:________ ______________
(If different than child's)

Languages spoken in the home: ____

Child is: Biological ________ Foster ___________ Adopted ______ If so, at what age: _____________

Child resides with:

Birth Mother	___
Birth Father	___
Adoptive Mother	___
Adoptive Father	___
Foster Mother	___
Foster Father	___

Other (specify) ___________________

Child has contact with, but doesn't reside with:

Birth Mother	___
Birth Father	___
Adoptive Mother	___
Adoptive Father	___
Foster Mother	___
Foster Father	___

Other (specify) ___________________

If custodial parents are separated, please describe current timeshare: __________________________

What are your major concerns regarding your child:
____
____
____
____
____
____
____

Have you consulted with any other professionals regarding these concerns: ___ Yes ___ No

If yes, please list any other professionals:

( ) Pediatrician:
( ) Developmental Pediatrician:
( ) Neuropsychologist:
( ) Educational Psychologist:
( ) Learning Specialist:
( ) School staff (Classroom Teacher, or Student Study Team Members):
( ) Preschool teachers:
( ) Audiologist:
( ) Other Specialists:

<u>Medical History</u>:

<u>Pregnancy</u>: ____ Normal/No complications
___ Complications: ___ Excessive Staining ___Threatened Miscarriage ___Infections
___ Toxemia ___Operations (specify) _______________
Other Illnesses: ____
Medications taken during pregnancy: ________________________
Drug use during pregnancy ____Cigarette Smoking ___Alcohol___
Other drugs: _____________________________________

Labor and Delivery:

Type of Labor: ___Spontaneous ___Induced
Duration of Labor: _______________

Type of Delivery: ___ Vertex/normal ___Breech ___Caesarian

Complications: ___ None ___Cord around the neck ___Hemorrhage ___
Other: ____

Birth Weight: _____ lbs. ____oz. Apgar Scores: _________________( ) Don't Recall

Post-Delivery (While in the hospital):

Complications: ___ None ___Respiratory/Breathing problems ___Jaundice ___
___ Low Tone/Neurological
___ Weak Suck ___ Vomiting ___Diarrhea ___ Infection
___ Birth Defects (specify) _________________________________
___ Other complications (specify) _________________________
____

Total number of days baby was in hospital after delivery _______

General Medical History:

( ) Chronic Colds/respiratory infections
( ) Chronic Ear Infections
( ) Asthma
( ) Allergies
( ) Tonsillitis
( ) Hearing Impairment
( ) Cerebral Palsy
( ) Temporary Hearing Loss
( ) High Fever
( ) Head Trauma
( ) Previously diagnosed global developmental delay
( ) Attention deficit disorder
( ) Eye Problems

( ) Other serious illness or condition: Please list and describe:
____
____
____

( ) Hospitalizations for illness or operations:
____
____

What medication(s) is your child taking? (name, dosage, how many times per day):
____
____

Development:

At what age did you first become concerned about your child, and why?
____
____

Infancy-Toddler Period

Were any of the following present, to a significant degree, during the first two years of life:

___ Separation from parents for a long time
___ Frequent hospitalization
___ Child resisted cuddling
___ Difficult to calm
___ Colicky
___ Restless
___ Inactive
___ Difficulty eating
___ Difficulty sleeping
___ Accident-Prone

___ Avoid eye contact
___ Nonresponsive when spoken to
___ Play with toys in unusual way
___ Failure to develop gestures
___ Failure to point to call attention or to request
___ Failure to coo or babble
___ Little turn-taking with vocalization between child and caregiver

Developmental Milestones:

Approximate ages when your child:

Smiled: ________
Sat without support: ________
Crawled: ________
Walked with assistance: ________
Spoke first words: ________
Said phrases: ________
Said sentences: ________
Self-feeding: finger food: ________
Cup/spoon: ________
Potty trained/by day: ________
Dressed self: ________

Coordination:

Do you have any concerns regarding your child's gross motor (large motor) and/or fine motor (small motor) skills? ___ No ___ Yes ___ Unsure If yes, please explain:
____
____

Sensory Issues:

Do you have any concerns about your child's sensory processing skills? For example, sensitivity to loud sounds, aversions to touch, taste, or smell, toe-walking, etc? ___ No ___Yes ___Unsure
If yes, please explain:
____
____
____

Comprehension and Understanding:

Do you consider your child to understand verbal directions and situations as well as other children his or her age? ________ If not, why?
____
____

School History: Please list all school placements, beginning with first preschool:

____
____
____
____
____

Describe your child's current educational program (name of school, grade, class size, special education services, if any, etc.):
____
____
____

Describe any reported behavioral concerns in the classroom:
____
____
____

Current Classroom Teachers and Classroom Aides:
____
____

Peer Relationships:

Does your child seek friendship with peers? _____________
Is your child sought by peers for friendship? _____________
Does your child play primarily with children his or her own age? Yes/No, If no, ___younger ___ older
Describe briefly any problems your child may have with peers:
____
____
____

Child Interests:

What are your child's main hobbies and interests?
____
____

Family History – Mother

Age: ____ Age at time of pregnancy with patient; ____

School: Highest grade completed: ____

Learning Problems: ___ Yes ___ No If "yes," please specify:
____

Medical Problems: ___ Yes ___ No If "yes," please specify:
____

Psychiatric Problems: ___ Yes ___No If "yes," please specify:
____

Speech or Language Problems: ___Yes ___No If "yes," please specify:
____

Have any of your blood relatives (not including patient and siblings) ever had problems similar to those your child has? ___ Yes ___No If "yes," please specify:
____

Family History – Father

Age: _____ Age at time of patient's conception: ___________

School: Highest grade completed: ____

Learning Problems: ___ Yes ___No If "yes," please specify:
____

Medical Problems: ___Yes ___ No If "yes," please specify:
____

Psychiatric Problems: ___ Yes ___No If "yes," please specify:
____

Speech or Language Problems: ___Yes ___No If "yes," please specify:
____

Have any of your blood relatives (not including patient and siblings) ever had problems similar to those your child has? ___Yes ___No If "yes," please specify:
____

Siblings:

	Name	Age	Medical, social or academic concerns
1.			
2.			
3.			
4.			
5.			

Additional Information:

Please use the remainder of this page to write any additional comments you wish to make regarding your child.