Participant #: _____

FOLLOW-UP SESSION #1 QUESTIONNAIRE
Please complete BOTH sides of this form.
Medical and Developmental History:

1. Has your child been diagnosed with any of the following? ***(check for 'yes')***

1. ADD/ADHD _____
2. AutismSpectrum Disorder _____
3. Cleft lip/palate _____
4. Ear infections _____

   If yes, when did he/she have his first ear infection and how many has he/she had?

   _____

5. Vision problems _____
6. Feeding/Swallowing problems _____
7. Hearing loss _____
8. Intellectual disability _____
9. Speech delay/disorder (difficulty making sounds) _____
10. Language delay/disorder (difficulty understanding and/or producing words and sentences) _____
11. Seizure disorder _____
12. Other (please specify) _____

2. Do you have any concerns about your child's development? YES / NO

If yes, please explain:_____

_____

3. Is your child currently receiving or have they ever received services related to delays in speech and/or language development? YES / NO
If yes, please complete* "Treatment history" *section on back side

4. Has your child had his/her hearing tested? YES / NO

If yes, when and where did the most recent testing occur and what were the results?

_____

_____

(please complete back side)

5. Has anyone in your child's close family (parents, brothers/sisters, aunts, uncles, cousins) had problems with speech or language? YES / NO

If yes, please describe:

_____

_____

Treatment History

1. When did your child first start receiving therapy? _____

2. Is your child still receiving therapy? YES / NO

3. If your child is no longer receiving therapy, when did therapy stop? _____

4. If your child is no longer receiving therapy, why was therapy discontinued?

   _____

5. Where is your child receiving therapy or where did they receive therapy?

   _____

6. How often and for how many minutes do/did they attend therapy?

   _____

7. Is/was the therapy group therapy or individual therapy? GROUP / INDIVIDUAL