Lawrence Speech & Hearing Services

Youth Speech Questionnaire

Patient Name: ____

What languages does the child speak:? ______________________________

Describe the child's speech-language difficulties. ______________________

____

When was the problem first noticed? By whom? ______________________

____

Has the problem changed since it was first noticed? ___________________

____

Is the child aware of the problem? If yes, how does he or she feel about it? ________

____

How does the child communicate wants or needs? (gestures, single words, short phrases, sentences?) ____

____

How well do you understand your child's speech? (eg. 50% of the time, 75% of the time) ______

____

Are there or have there ever been any feeding difficulties with: sucking, swallowing, drooling, chewing)? ____

____

Are there any other speech, language, or hearing problems in your family? If yes, please describe. ____

____

Person completing form:______________________________________
Relationship to child: ______________________________________

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