6317 Highway 329
Crestwood, KY 40014

PHONE
502.384.0910

FAX
502.384.0908

Parent Interview

Name: _____ **DOB:** _____ **Date:** _____

Parents: _____

Address: _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email Address:** _____

1. Describe concerns: _____

2. What do you consider your child's greatest strengths? _____

3. Describe any skills that you feel are emerging: _____

4. Who else lives in your home? _____

5. Are languages other than English spoken in the home? yes no

If *yes*, please list. _____

HEALTH/DEVELOPMENTAL HISTORY

6. Were there difficulties during pregnancy? yes no Length of pregnancy? _____

If *yes*, describe: _____

7. Describe your child's delivery and birth: Weight: _____

typical spontaneous induced

Caesarian breech unusually long labor

8. Describe your child's condition at birth:

typical birth injury/defect jaundiced

breathing problems low birth weight

Other: _____

9. Is there a history of any of the following conditions:

intubation/ventilation hospitalization surgery

chronic/severe illness high/prolonged fever seizures

serious accidents head injury reflux

excessive drooling | allergies | asthma

ear infections | ear tubes (include date) | hearing loss

Explain any circled areas: _____

_____

10. List any medications your child is currently taking: _____

_____

11. Has your child every had a hearing evaluation: yes no

If *yes*, when? _____ Results: _____

12. Has vision been tested? yes no

If *yes*, when? _____ Results: _____

13. At what age did your child attain the following skills:

sitting _____ crawling _____ standing _____

walking _____ 1st words _____ toileting _____

14. Has your child been evaluated by any other professional? (Circle all that apply)

occupational therapist | educator/teacher

physical therapist | geneticist

developmental interventionist | physician

developmental pediatrician (specialist) | nutritionist

psychologist/psychiatrist | neurologist

15. Does your child have a diagnosis from any of the above professionals? yes no

If *yes*, please list date professional and diagnosis for each. _____

_____

_____

16. Since birth have there been any of the following:

Accidents yes no

If *yes*, please describe. _____

Illnesses yes no

If *yes*, please describe. _____

Surgeries yes no

If *yes*, please describe. _____

SPEECH/LANGUAGE HISTORY

17. Is there a family history of speech, language, hearing, or learning problems? yes no

If *yes*, describe: _____

_____

18. Has your child had a previous speech-language evaluation? yes no

If *yes*, please list dates and results. _____

_____

_____

19. Has your child had previous speech-language therapy? yes no

If *yes*, please list dates and settings, and therapists. _____

_____

20. If your child had speech-language therapy, what kind of progress did your child make? _____

_____

Were you pleased with your child's progress? yes no

Please explain. _____

21. Did your child babble? yes no

If *yes*, did he/she use a variety of sounds? yes no

22. At what age were your child's first words? _____

Please list a few. _____

23. Does your child have a history of using words several times and then never again? yes no

24. Is your child reluctant or communicate or become frustrated when trying to speak? yes no

If *yes*, please describe. _____

25. Circle the speech sounds your child currently uses:

vowels	long	a	e	i	o	u	
	short	a	e	i	o	u	
consonants	p	b	m	w	t	d	n
	f	v	k	g	h	s	z
	sh	ch	j	y	l	r	th

26. Approximately how much of your child's speech can you understand?

Less than 25% 25% 50% 75% 100%

27. Can people outside the family understand your child's speech? yes no

28. How does your child typically communicate with others? (Circle all that apply)

talking gestures facial expressions signs

pulling/leading pictures crying pointing

other _____

29. Does your child play and communicate well with his/her friends and family? yes no

If *no*, please describe. _____

30. Does your child seem to understand most of what you say or tell him/her? yes no

31. Does your child have difficulty following directions? yes no

If *yes*, please describe. _____

32. How many words does your child use? 0-20 21-50 51-100 101-200 more than 200

33. What is the average phrase length your child uses?

1 word 2 words 3 words 4 words longer than 4 words

34. Does your child: (check *yes* or *no* for each)

	yes	*no*
ask questions to gain information	☐	☐
understand vocabulary	☐	☐
use age-appropriate vocabulary	☐	☐

stay on subject in conversation	☐	☐
take turns when talking to someone	☐	☐
describe and explain	☐	☐
answer questions	☐	☐
put words together clearly to form a sentence	☐	☐
use complete sentences (conjunctions, etc.)	☐	☐
use correct grammar such as plurals, verb tense, pronouns	☐	☐

AUDITORY PROCESSING and LEARNING

35. Does your child have difficulty with any of the following? (Circle all that apply)

memory tasks	remembering and following directions
comprehension	putting thoughts together
word retrieval	difficulty learning or using new vocabulary

36. Did your child have difficulty learning early academic skills such as matching, identifying same/different, and/or knowing names of colors, shapes, numbers and letters? yes no

If *yes*, please describe. _____

37. Does your child have difficulty with leaning skills in reading, math, spelling, other? yes no

If *yes*, please describe. _____

VOICE and FLUENCY

38. Is your child's voice clear? yes no

If *no*, please describe. _____

39. Describe your child's voice. (Circle all that apply)

nasal	soft	monotone
denasal (sounds like he/she has a cold)	high-pitched	breathy
loud	low-pitched	hoarse

40. Does your child talk smoothly without repeating sounds or words? yes no

If *no*, does he/she have trouble getting words out? yes no

If *yes*, please describe. _____

FEEDING HISTORY

41. What is child currently eating/drinking? _____

_____

42. Is your child:

self feeding	yes	no
finger feeding	yes	no
utensils	yes	no

43. Does your child have a history of feeding difficulties? yes no

If *yes*, circle all that apply:

poor nursing	gagging	choking

difficulty biting | difficulty chewing | difficulty swallowing

overstuffing mouth | spitting food out of mouth | holding food in his/her mouth

other _____

44. Is your child a messy or picky eater? yes no

SENSORY and MOTOR

45. Does your child have any difficulty walking, running, sitting or other large motor skills? yes no

If *yes*, please describe. _____

46. Is your child clumsy or does he/she fall easily? yes no

47. Does your child have low body tone? yes no

48. Does your child have difficulty with fine motor skills such as stacking, cutting and handwriting? yes no

If *yes*, please describe. _____

49. Is your child sensitive to certain textures of food or clothing? yes no

If *yes*, please describe. _____

50. Does your child dislike having substances on his/her hands such as glue, food, or dirt? yes no

51. Is your child oversensitive to being touched/dislikes being touched? yes no

If *yes*, please describe. _____

52. Does your child play in an overly rough way? (purposefully crashing into walls, furniture, people) yes no

If *yes*, please describe. _____

53. Circle all that apply regarding your child.

dislikes washing face or hair | does not demonstrate caution

dislikes haircuts | puts things in his/her mouth besides food

spends too little or too much time brushing teeth | chews on his/her clothes

BEHAVIOR

54. Does your child typically display any of the following behaviors? (circle all that apply)

reduced or lack of interactions with others | difficulty staying on task

tantrums | difficulty finishing tasks

passive in interactions | sensitive

very active | poor eye contact

under active | angry/acting out behavior

inattentive | frustrated

refuses to perform tasks | shy

OTHER INFORMATION

55. Does child attend any preschool, Mother's Day Out, etc? yes no

If *yes*, list days and times. _____

56. What is best day/time for therapy? _____