ALL ABOUT
SPEECH & LANGUAGE

Re-evaluation Parent Questionnaire

Patient name_____ Birthdate _____

Pediatrician_____

Specialists such as ENT, Allergist, etc. (list all):

_____

_____

Any upcoming appointments? _____

_____

Any changes in doctors or changes to diagnosis? _____

_____

Allergies/Precautions? _____

Safety issues? _____

Current Medications:

Name	Dose	Frequency	Purpose	Method
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Method choices might include: IV, NG tube, Nebulizer, Aerosol, by mouth

List child's equipment (AFOs, bath chair, gait trainer, adaptive stroller, splints):

_____

School, Daycare, or Preschool: _____ Grade: _____

List special education services/type of classroom: _____

_____

Other outside therapy? PT, OT, ST, ABA? Frequency of each and Provider:

_____

_____

PT, OT, ST in school setting? If so, Type and Frequency:

_____

Eating: Any changes in foods the child eats? Any specific concerns?

_____

_____

Sleep: Any concerns with getting to sleep or staying asleep? Please specify.

_____

_____

Behavior: Any concerns (transitions, tantrums, aggression, separation from parent, repetitive behaviors, etc.)? Please specify and/or provide an example.

_____

_____

School skills: Any concerns from the teacher, attention, following directions, etc.? Please specify and/or provide an example.

_____

_____

Social skills: Any concerns with turn taking, making friends, play skills, peer/sibling interactions, etc.? Please specify and/or provide an example.

_____

_____

Top **Speech** Priorities/Concerns:

1._____

2._____

3._____

Top **OT** Priorities/Concerns:

1. _____

2. _____

3._____