Speech Sounds Parent Input

Student Name: ______________________ **Date of Birth:** ______________

Person Completing the Form: ______________________ **Date:** ______________

Is there a background of any significant medical history? (i.e. ear infections, tonsils & adenoids, allergies, snoring, tongue/lip tie, or delayed developmental milestones such as cooing/babbling, etc.)

What are your concerns regarding your child's articulation skills? Please check all that apply:

- ☐ Child deletes sounds when speaking
- ☐ Child distorts sounds when speaking (i.e., lisp)
- ☐ Child changes sounds when speaking
- ☐ Other:

	Yes	No	Sometimes
Does your child ever appear frustrated by his/her speech difficulty?			
Does your child avoid speaking due to his/her speech difficulty?			
Is it difficult for you to understand your child?			
Is it difficult for family members to understand your child?			
Is it difficult for unfamiliar listeners to understand your child?			
Do you have to repeat or interpret what your child said to others?			

	Yes	No
Has your child ever failed a hearing screening/evaluation? If yes, was the problem resolved? Please explain:		
Is there a language other than English that is spoken in the home? If yes, what language(s)?		
Is there a family history of speech difficulties? If yes, who?		
Do you feel your child's articulation difficulties impact him/her at home? If yes, please explain:		
Do you feel your child's articulation impacts him/her academically or socially at school? If yes, please explain:		

Please describe any additional concerns you have regarding your child (continue on the back of this page, if needed):