# Speech Sounds Student Input

Student Name: _____ Grade/Homeroom: _____

Please provide any relevant 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 articulation skills? Please check all that apply:

- ☐ I delete sounds when speaking
- ☐ I distort sounds when speaking (e.g., lisp)
- ☐ I change sounds when speaking
- ☐ Other:

| | Yes | No | Sometimes |
|---|---|---|---|
| Do you think you have a speech problem? | | | |
| Are you frustrated by your speech? | | | |
| Are you embarrassed by your speech? | | | |
| Do you avoid speaking because of your speech? | | | |
| Are you told that you are difficult to understand? | | | |
| Are you asked to repeat yourself often? | | | |

How does your articulation difficulty impact you educationally?

How does your articulation difficulty impact you socially and/or vocationally?

What sounds do you think you need to work on?

What are your goals in speech therapy?

Additional comments?

Date completed: _____