Kidz Therapy Zone
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Allen, TX 75013
Phone (214) 509-6961
frontdesk@kidztherapyzone.com

SPEECH-LANGUAGE THERAPY SUPPLEMENT

Child's Name:	Date:

GENERAL:
What is the reason you are seeking a Speech-Language Therapy evaluation and services? Please list your primary concerns.
Please describe your child's communication strengths:
What do you hope your child will accomplish in a speech-language therapy program?
Please add any other comments or descriptions that will help us better understand your child and concerns:

LANGUAGE SKILLS:
Which of the following does your child use to communicate? ☐ **Spoken language** ☐ **Picture exchange** ☐ **Communication device** ☐ **Signs**
If spoken language, does your child typically use: ☐ **Single words** ☐ **2-3 word combinations/phrases** ☐ **Sentences** ☐ **Conversation**
If picture exchange or communication device, please identify the program your child uses:
If signs, please list some signs in your child's repertoire:

LANGUAGE SKILLS - Continued

Please indicate the various ways in which your child uses communication at home:

☐ Request help ☐ Requests items/activities ☐ Greetings ☐ Comments
☐ Asks questions ☐ Answers questions ☐ Negation/Refusals ☐ Expresses feelings

Please list concerns you have regarding your child's receptive language (e.g., comprehension/knowledge of language and vocabulary, following directions, answering questions, etc.).

Please list concerns you have regarding your child's expressive language (e.g., omitting words, mixing pronouns, incorrect verb usage, limited vocabulary, etc.)

Social Language Skills – Please check off skills that are DIFFICULT for your child:

☐ Conversational turn-taking	☐ Using appropriate volume	☐ Using intonation/inflections
☐ Maintaining topic of conversation	☐ Using/shifting eye-contact	☐ Appropriate body positioning
☐ Using/understanding facial expressions	☐ Understanding fact vs. fiction	☐ Understanding non-literal language

ARTICULATION SKILLS:

Please list any speech sound errors you notice at home (e.g., "wabbit" for "rabbit," "tup" for "cup," etc.).

Are there any words in particular that impact your child's daily routine (e.g., own name, siblings names, favorite toys, etc.). Please list below:

How much of your child's speech do you understand? (e.g., 50% of the time, 80%, etc.).

Does your child have a cleft palate or lip that was surgically repaired? ☐ Yes ☐ No

Is your child currently under the care of an orthodontist for expander/braces/etc.?

*If you have concerns regarding stuttering, please ask the front desk for our separate Stuttering Questionnaire.