New Patient Speech Questionnaire

Pt Name: DOB:

Phone Number:

Parent's name: State:

1. What are your concerns regarding your child's speech and language?

   SP -

   Lang-

2. Is it difficult for you to understand what they are saying? If yes- Articulation

   Yes: ☐ No: ☐

3. Do they stutter? If yes-Fluency

   Yes: ☐ No ☐

4. Is your child using a variety of words? If no-Language

   Yes ☐ No ☐

5. Are they putting words together to form sentences? If no-Language

   Yes ☐ No ☐

6. Does your child have appropriate social skills? If no-Pragmatics

   Yes ☐ No ☐

7. Are you concerned about their feeding skills? If yes-Feeding

   Yes ☐ No ☐

8. Which school or daycare do they attend?

9. Does your child receive services through the school? Yes/ No If yes what school.

10. What hours is your child available for therapy during the day? AM/ PM

11. Has your child received services at another clinic?

12. Is it ok to leave a detailed message on voicemail?
Yes ☐ No ☐
Is it ok to send text messages for appointments?
Yes ☐ No ☐

Do you have any questions for Building Blocks Physical Therapy?

No show policy: 3 no show appointments, and your child may be discharged.

X _____

Parent Signature Date