Time 2 Talk, LLC

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PARENT QUESTIONNAIRE

Welcome to Time 2 Talk! Please provide the following information about your child. Thank You!

GENERAL INFORMATION

Child's Name: ____DOB: _____________________

Nickname (if any): ____

All persons living in the home with child

Name	Relationship	Age

Legal relationship of guardian to child:

	Biological parent
	Step- Parent
	Grandparent
	Adoptive Parent
	Foster Parent
	Other (please specify):

Child's Development

How old was your child when you first had concerns about their development? ___________________________

Is your child currently or have they received Early Intervention services? Indicate all that apply.

	Developmental Therapy
	Speech Therapy
	Occupational Therapy
	Physical Therapy
	Nutrition services
	Social-Emotional services
	My child has not received Early Intervention services

Does your child show any behaviors that are concerning to you or others (specify)? ________________________

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Speech Development (if child does not consistently show skill, indicate no)

YES / NO	Does your child talk?
YES / NO	Does your child use their language to communicate their wants and needs?
YES / NO	Does your child respond appropriately to questions?
YES / NO	Do you understand your child's speech if you don't know what they are trying to tell you?
YES / NO	Do others understand your child's speech?
YES / NO	Has your child made up words for things?
YES / NO	Does your child show frustration if unable to communicate what they want you to know?
YES / NO	Does your child follow directions and show they understand what you are saying to them?
YES / NO	Does your child imitate words when asked?
YES / NO	Does your child use scripted speech (from a TV show or video or something they have heard repeatedly?

Please indicate all that apply. How does your child communicate?

	Vocalizing/using word approximations and or jargon we don't understand
	Gestures and or signs
	Facial expressions
	Pushing or pulling adult to what they want or bringing item to adult
	Becomes emotional/tantrum/crying
	Pointing and grunting
	AAC device

Feeding

Is your child's weight a concern (if yes, please explain)? ____

____

Does or has your child ever had a feeding tube? ____

My child

	Breastfeeds		Drinks from the breast		Drinks using a straw
	Formula feeds		Drinks from a bottle		Drinks from an open cup
	Eats purees		Drinks from a spouted sippy cup		Uses utensils to eat
	Eats table food		Drinks from a 360 sippy cup		Eats with hands

Did or Is your child struggling with latching at the breast or bottle feeding? _____________________________

Did or is your child having trouble transitioning to solid foods? ____

Does your child have difficulty swallowing? ______________________ Drool? ___________________________

While eating, my child

	Refuses foods		Food drops from mouth		Tires easily/falls asleep
	Presses lips tight		Liquids spill from mouth		Pockets food in cheeks
	Gags		Sits in a highchair		Takes a while to finish
	has a poor appetite		Uses a booster		Coughs
	Chokes		Sits at child-size table		Overstuffs mouth
	Arches back		Throws food		Has wide or watery eyes
	Screams/Cries		Grazes		

Please list any foods that are difficult for your child to eat ____

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Please list any textures your child avoids (include hot or cold foods) ____________________________________

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Please list any food allergies/sensitivities ____

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Social-Emotional Development

My Child

	Is home with mom and or dad during the day
	Is watched by other family members at our home or theirs
	Attends an in-home daycare setting with other children
	Attends a daycare facility with other children
	Is school age
	Participates in play groups or age-appropriate sports/other activities with peers
	Does not have the opportunity to socialize with same-age children

Does your child play appropriately with toys or prefer to move and carry items around? ___________________

____

Does your child enjoy playing with other children or prefer to keep to self? _______________________________

If playing with others, can your child sit and do back and forth play or do they prefer motor activities such as running or chasing games? ____

Can your child be flexible with play routines or do things have to be their way/idea?

____

Can your child move between activities easily or do they have trouble moving away from doing a preferred activity?

____

What activities does your child enjoy doing at home? ____

____

Does your child seek help appropriately or just quit/give up? ____

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Do the discipline strategies you use with your child work (they learn from what they did, or behaviors continue?) ____

Have you ever had to leave someplace because of your child's behavior? ________________________________

Do you feel your child needs to be disciplined

	More than other children the same age, we really seem to struggle with making good choices and treating others well
	Less than other children the same age, my child does not often need redirected
	About the same as their peers, my child can test limits at times but learns from consequences

Family History

Does your child have family members (grandparent, parent, sibling, aunt, uncle or cousin) with any of the following? Please note who.

	Speech/Communication Disorder
	Stuttering
	Autism Spectrum Disorder
	Developmental Delay not specified
	Reading or Learning Disability
	Behavior concerns
	Eating Disorder
	Hearing Loss

Please share with us any information you feel is important for us to know about your child that may help us better meet their needs. ____

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What are your child's strengths? ____

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We believe all of your hopes and dreams for your child are within reach!