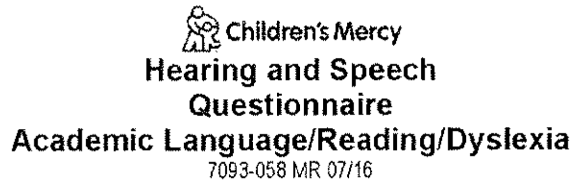

Hearing and Speech Questionnaire Academic Language/Reading/Dyslexia

7093-058 MR 07/16

Child's Name:____

Date of Birth: ____/____/_____ Age: _______ Sex: ☐ Male ☐ Female Language: ______________________

Appointment Date: _____/_____/_____ Time: _____:_____ ☐ AM ☐ PM

Please arrive 15 minutes before your appointment time.

YOUR VISIT IS SCHEDULED AT THE LOCATION CHECKED BELOW:

☐ **Children's Mercy Kansas College Boulevard Clinics**
5520 College Blvd Ste 370
Phone: 913-696-5750
Fax: 913-696-5761

☐ **Children's Mercy Northland**
501 NW Barry Road
Kansas City, MO 64155
Phone: 816-413-2500
Fax: 816-234-3291

☐ **Children's Mercy East**
20300 E Valley View Pkwy
Independence, MO 64057
Phone: 816-478-5200
Fax: 816-478-5294

☐ **Scottish Rite Temple**
1330 E Linwood Blvd
Kansas City, MO 64109
Phone: 816-561-2277, ext 108

BEFORE YOUR APPOINTMENT:

- Please complete and return this questionnaire in the provided envelope along with the following requested paperwork at least **ONE MONTH PRIOR TO YOUR APPOINTMENT:**
  - Individual Education Plan (IEP) and/or 504 Plan
  - Any formal testing completed by a speech-language pathologist, learning disability teacher, reading tutor, and/or psychologist in school or from an outside agency
  - Writing sample
  - Recent photo of child
- Register online at: http://www.childrensmercy.org and click on *Parents & Children*, click on *Pre-Registration*, choose *Hearing and Speech Clinic* or *Hearing & Speech* from the appropriate drop-down menu. Complete the registration form at least one week before your visit.
- If you have commercial insurance: Verify coverage. Have your physician complete all necessary referral or authorization forms. Fax to the number shown for the location of your appointment. You may also send or bring them with your other paperwork.
- Children's Mercy Hospital (CMH) accepts Medicaid.
- Contact the CMH Financial Counseling office at (816) 234-3567 to discuss additional options.
- Arrange child care for any other children.

****IF YOU NO LONGER NEED THIS APPOINTMENT, PLEASE LET US KNOW SO WE MAY OFFER THIS APPOINTMENT TIME TO ANOTHER FAMILY****

ON THE DAY OF YOUR VISIT:

- Allow a full 3-3.5 hours for your visit.
- Feed your child before coming or bring a snack.
- You will be asked to remain with your child and to provide input during the evaluation.

Children's Mercy

Hearing and Speech Questionnaire
Academic Language/Reading/Dyslexia

7093-058 MR 07/16

GENERAL INFORMATION

Address:____
Street City State Zip

Home Phone Number: (____)_______-__________ Alternate Phone Number: (____)_______-__________

Father/Guardian: ____

Language:__________ Age: _______ Living in the Home? ☐ No ☐ Yes

Highest School Grade Completed: _________ Occupation:__________________Employer:__________________

Home Phone: (____)_____-________ Work Phone: (____)_____-_____Other Phone: (____)______-__________

Mother/Guardian: ____ **Language:**__________

Age: _______ Living in the Home? ☐ No ☐ Yes

Highest School Grade Completed: _________ Occupation:__________________Employer:__________________

Home Phone: (____)_____-__________ Work Phone: (____)_____-__________Other Phone: (____)___-________

Emergency Contact/Relationship to Child:____________________Phone Number: (____)____-__________

Brothers and Sisters:

Name	Sex	Age	Living in the home?	Problems Past and Present
	☐ Male ☐Female		☐No ☐Yes	
	☐ Male ☐Female		☐No ☐Yes	
	☐ Male ☐Female		☐No ☐Yes	
	☐ Male ☐Female		☐No ☐Yes	

Primary Care Physician (PCP): ________________________Office Phone Number: (____)_____-________

Address:____
Street City State Zip

School:____Phone Number: (____)_______-__________

Teacher/Contact Person:_________________________________Fax Number: (____)_______-__________

Address:____
Street City State Zip

Grade: ______ Does your child have an IEP and/or 504 plan? _______ If yes, please provide a copy.

Does your child receive reading intervention currently or has your child received reading intervention? __________

If yes, please explain:

____

Referral Source: _________________________________Office Phone Number: (____)_____-________

Has your child been seen at Children's Mercy? ☐ No ☐ Yes (see below)

If yes, which clinic/unit and when?____

REASON FOR VISIT

Describe the problem(s) that your child is having and when you first noticed:______________________

____

____

____

What goals would you like to see accomplished as a result of this evaluation?______________________

____

MEDICAL HISTORY

1. Current medications, including vitamins, herbal supplements, over-the-counter (list names and what for):

____

____

2. Adverse Reactions ____ ☐ No adverse reactions.

Children's Mercy

Hearing and Speech Questionnaire Academic Language/Reading/Dyslexia

7093-058 MR 07/16

3. Check all that apply to your child now or in the past:

- ☐ Asthma
- ☐ Attention deficit (hyperactivity) disorder (ADD/ADHD)
- ☐ Attention concerns
- ☐ Autism
- ☐ Behavior problem
- ☐ Breathing trouble, with or without exercise
- ☐ Clumsiness
- ☐ Difficulty learning the days of the week
- ☐ Difficulty learning to tie shoes
- ☐ Difficulty learning letter-sound correspondence
- ☐ Difficulty establishing hand dominance/mixed after age 4
- ☐ Ear pain or infection
- ☐ Easily distracted
- ☐ Emotional problems
- ☐ Feeding/eating concerns/problem
- ☐ Frequent colds, sinus problems, or fluid drainage
- ☐ Frequent coughing
- ☐ Hearing problem or trouble listening or understanding under certain conditions
- ☐ Heartburn or reflux
- ☐ High fevers
- ☐ Hoarseness
- ☐ Inability or unwillingness to sit still
- ☐ Lack of coordination
- ☐ Lack of playmates (or playmates his or her age)
- ☐ Learning disability or slow learner
- ☐ Difficulty learning how to tell time
- ☐ Difficulty learning left and right (directionality)
- ☐ Difficulty learning math and quantity concepts (such as one, two, more, less, all, some, none, except)
- ☐ Difficulty learning nursery rhymes or children's songs
- ☐ Difficulty learning series of numbers (telephone numbers, addresses, birth dates, etc)
- ☐ Difficulty learning the names of letters
- ☐ Letter/number reversal after 2 years of handwriting instruction/practice
- ☐ Multiple handicaps (list below)
- ☐ Not following directions
- ☐ Poor memory (forgetfulness)
- ☐ Poor handwriting
- ☐ Poor spelling
- ☐ Difficulty pronouncing words with more than one syllable
- ☐ Reading intervention
- ☐ Difficulty recognizing familiar signs, shapes, or colors
- ☐ Difficulty retelling events meaningfully and sequentially (in order)
- ☐ Seasonal allergies (hay fever)
- ☐ Sleep concerns
- ☐ Speech or language problem (i.e. difficult to understand; trouble reading or spelling)
- ☐ Stuttering
- ☐ Temper tantrums
- ☐ Difficulty understanding temporal concepts (such as before, after, next, first, last)
- ☐ Upper respiratory illness/infections
- ☐ Vision problem
- ☐ Other health problem or major illness

4. Describe any concerns with items checked above and provide the information below for specialists somewhere other than CMH.

- Name of specialist or service provider: ____________________

Type of professional or specialist: ☐ Counselor/Psychologist ☐ Psychiatrist ☐ Physical/Occupational Therapist ☐ Audiologist ☐ Speech/Language Pathologist ☐ Other: ____________________

Phone: (_____)________-___________ Address: ____________________

Type of evaluation, testing, and/or treatment services: ____________________

What for?____________________

When and how long were services provided? ____________________

Results:____________________

- Name of specialist or service provider:____________________

Type of professional or specialist: ☐ Counselor/Psychologist ☐ Psychiatrist ☐ Physical/Occupational Therapist ☐ Audiologist ☐ Speech/Language Pathologist ☐ Other: ____________________

Phone: (_____)________-___________ Address: ____________________

Type of evaluation, testing, and/or treatment services:____________________

What for?____________________

When and how long were services provided? ____________________

Results:____________________

5. Has your child been hospitalized? ☐ No ☐ Yes, explain:____________________

____

____

6. Has your child had surgery? Check and give dates for all that apply:

☐ Tonsillectomy: ____/____/____ ☐ Ear tubes: ____/____/____ ☐ Adenoidectomy: ____/____/____

☐ Other: ________________________, ____/____/____ ☐ Other: ______________________, ____/____/____

7. Have any of your child's relatives had any of the following? (Check and explain all that apply.)

☐ Hearing problems or hearing loss: ____________________

☐ Speech or language problems: ____________________

☐ Reading or learning problems: ____________________

☐ Attention problems: ____________________

☐ Hyperactivity: ____________________

☐ Spelling difficulties: ____________________

☐ Writing difficulties: ____________________

BIRTH HISTORY AND GENERAL DEVELOPMENT

1. Child's birth weight: _____ lbs _____ oz
2. Check all that apply: ☐ Full term ☐ Premature, _____ weeks ☐ Normal delivery ☐ Cesarean
3. Did the mother have complications or health problems during pregnancy? ☐ No ☐ Yes, describe:___________

____

____

4. Did your child have trouble learning to suck as a newborn? ☐ No ☐ Yes, explain: ____________________
5. Check each developmental milestone your child has reached, and write what age your child first did each one:

☐ Sit alone: _______ ☐ Walk alone: _______ ☐ Eat with a spoon: _______

☐ Drink from a bottle: _______ ☐ Drink from a cup: _______ ☐ Eat table food: _______ ☐ Feed self: _______

☐ Fasten buttons: _______ ☐ Take off coat: _______ ☐ Dress self: _______

☐ Follow simple directions: _______ ☐ Respond to his/her name: _______

☐ Say first words (begin babbling): _______ ☐ Say "mama" or "dada" with meaning: _______

☐ Use 2-3 word sentences: _______

☐ Describe activities to others: _______ ☐ Engage in conversations: _______

6. Were there any concerns about your child reaching developmental milestones such as walking and/or talking? ☐ No ☐Yes If yes, explain: ____________________
7. How often does your child read for pleasure? ____________________

____________________ Signature of Person Completing This Form

____________________ Printed Name of Person Completing This Form

____________________ Relationship to Child

_____/_____/_____ Date