PICKERINGTON LOCAL SHOOL DISTRICT

SPEECH PATHOLOGIST'S SURVEY

Child's Name _____

Parent's Name _____

Child's Birthdate _____

Phone Number _____

My child has had a history of ear problems (ear infections, Serous Otitus Media, known hearing loss).

Yes____ No _____ If yes, list the type of problems, and the name of your Ear, Nose and Throat Specialist or attending physician_____

Approximate number of ear infections as a preschooler _____

Does your child have a hearing loss? Yes _____ No _____

If yes, does he/she wear hearing aids/amplification? Yes _____ No _____

My child has a speech and/or language problem(s). Yes _____ No _____

My child has received private therapy for speech and/or language problem(s). Yes _____ No _____

If yes, where: _____

Describe your child's basic speech and/or language problem(s).

_____

_____

_____

_____ I am concerned about my child's speech and/or language development and would like the speech pathologist to screen my child.

Signature _____ Date _____