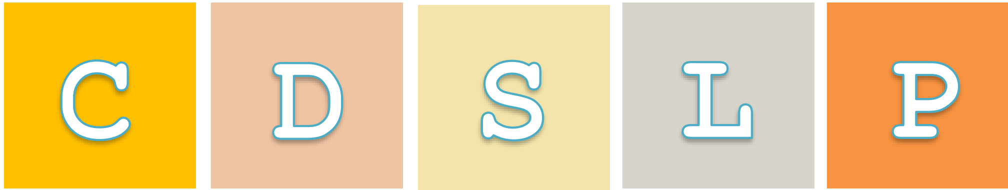

Central Delaware Speech Language Pathology, Inc.

Specializing in the Diagnosis and Treatment of Speech-Language Disorders
ASHA Certified, Licensed in Delaware

Speech and Language Reassessment Questionnaire

Please complete all applicable questions in full detail. If you have any questions, please ask!

Today's date: ______________________________ Child's Name: ___________________________

Date of birth: ______________________________ Gender: ____________________________

Address: ___________________________________ Home Phone: __________________________

____ Email Address: _________________________

Mother's Name: ___________________________ Cell Phone: ______________________________

Father's Name: ___________________________ Cell Phone: ______________________________

Does the child live with both parents? ____

If no, with whom does the child live? ____

Primary Care Physician: ____

Insurance Information:

Primary:

Company:________________________________ ID#_______________________________________

Group#_________ Policy Holder:__________________________ Relation to Patient:___________

Secondary (If applies):

Company:________________________________ ID#_______________________________________

Group#_________ Policy Holder:__________________________ Relation to Patient:___________

Describe your child's current speech-language/communication difficulties:

☐ Stuttering/Fluency ☐ Reading ☐ Voice ☐ Verbal Expression
☐ Functional Communication ☐ Speech (Articulation) ☐ Listening Comprehension ☐ Other: _____________
☐ Language ☐ Social Skills ☐ Vocabulary

Please describe the marked concerns below:

What are your goals in securing therapy for your child?

How do you feel your child has been progressing?

Is there anything we should know about your child/family that might have an effect on their progress in speech therapy?

Are there any health concerns for your child?

What is your child's current educational placement? Is there an IEP in place?

Please list any other doctors/specialists who have seen your child (audiologists, psychologists, occupational therapists, special educators, etc.). Please indicate the type of specialist, when the child was seen, and the specialist's conclusion or suggestions.

Name of Doctor/Specialist	Date(s) of Treatment/Evaluation	Please explain conclusions/ treatments if applicable

Medications

Please list any **current** medications your child is currently taking:

Allergies

Please list any **current** allergies that your child has.

Who is your child's therapist?

Kati Donna Christine Allison Caroline Shawna

Please tell us how you feel about our office space.

1. Do you find our front desk staff helpful and friendly?
   Very Somewhat Not Helpful

2. Do you find the waiting area comfortable and clean?
   Very Somewhat Not Comfortable

   Comments:____

Please tell us a little about your experience with your child's therapist

1. Do you feel your child's therapist takes time to build a positive relationship with your child?
   Yes Somewhat No

2. Does your child's therapist provide ongoing feedback and suggestions regarding your child's progress?
   Yes Somewhat No

Please tell us a little about your interests and overall experience.

1. Would you be interested in participating in additional programming such as social skills groups, parent workshops, other?

   ____

2. How has CDSLP made a difference in the life of your child, or your family?

____

____

3. May we **anonymously** share your feedback, including on social media? All identifying information will be excluded.
   ☐ Yes ☐ No

________________________________ ________________________

Signature Date

Thank you for your feedback.
Please write any further comments on the reverse side.

541 S. Red Haven Lane, Dover, DE 19901 (Phone) 302-674-3350 (Fax) 928-752-335