



**SPEECH-LANGUAGE  
THERAPY SUPPLEMENT**

Kidz Therapy Zone  
1101 Central Expressway S. Suite 185  
Allen, TX 75013  
Phone (214) 509-6961  
frontdesk@kidztherapyzone.com

Child's Name:	Date:
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**GENERAL:**

What is the reason you are seeking a Speech-Language Therapy evaluation and services? Please list your primary concerns.

Please describe your child's communication strengths:

What do you hope your child will accomplish in a speech-language therapy program?

Please add any other comments or descriptions that will help us better understand your child and concerns:

**LANGUAGE SKILLS:**

Which of the following does your child use to communicate?

- Spoken language     Picture exchange     Communication device     Signs

If spoken language, does your child typically use:

- Single words     2-3 word combinations/phrases     Sentences     Conversation

If picture exchange or communication device, please identify the program your child uses:

If signs, please list some signs in your child's repertoire:

**LANGUAGE SKILLS - Continued**

Please indicate the various ways in which your child uses communication at home:

- |                                         |                                                    |                                            |                                             |
|-----------------------------------------|----------------------------------------------------|--------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Request help   | <input type="checkbox"/> Requests items/activities | <input type="checkbox"/> Greetings         | <input type="checkbox"/> Comments           |
| <input type="checkbox"/> Asks questions | <input type="checkbox"/> Answers questions         | <input type="checkbox"/> Negation/Refusals | <input type="checkbox"/> Expresses feelings |

Please list concerns you have regarding your child's receptive language (e.g., comprehension/knowledge of language and vocabulary, following directions, answering questions, etc.).

Please list concerns you have regarding your child's expressive language (e.g., omitting words, mixing pronouns, incorrect verb usage, limited vocabulary, etc.)

**Social Language Skills – Please check off skills that are DIFFICULT for your child:**

- |                                                                 |                                                         |                                                             |
|-----------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Conversational turn-taking             | <input type="checkbox"/> Using appropriate volume       | <input type="checkbox"/> Using intonation/inflections       |
| <input type="checkbox"/> Maintaining topic of conversation      | <input type="checkbox"/> Using/shifting eye-contact     | <input type="checkbox"/> Appropriate body positioning       |
| <input type="checkbox"/> Using/understanding facial expressions | <input type="checkbox"/> Understanding fact vs. fiction | <input type="checkbox"/> Understanding non-literal language |

**ARTICULATION SKILLS:**

Please list any speech sound errors you notice at home (e.g., "wabbit" for "rabbit," "tup" for "cup," etc.).

Are there any words in particular that impact your child's daily routine (e.g., own name, siblings names, favorite toys, etc.). Please list below:

How much of your child's speech do you understand? (e.g., 50% of the time, 80%, etc.).

Does your child have a cleft palate or lip that was surgically repaired?  Yes  No

Is your child currently under the care of an orthodontist for expander/braces/etc.?

\*If you have concerns regarding stuttering, please ask the front desk for our separate Stuttering Questionnaire.