

KINDERGARTEN
SPEECH/LANGUAGE QUESTIONNAIRE

Clinical Speech/Hearing Department
Grant Wood rea Education Agency

Child: _____

Birthdate: _____

Parent/Guardian: _____

Street Address: _____

City: _____ Zip: _____

Home phone: _____ Work Phone _____

Date: _____

Please circle "yes" or "no" on the following questions.

1. Do Family members and other people frequently have difficulty understanding your child's speech?
YES NO
2. Does your child ever become frustrated with his/her speech or language? YES NO
3. When your child talks, are his/her sentences often less than five words in length? YES NO
4. Does your child have difficulty understanding directions? YES NO
5. Does your child have difficulty carrying on a conversation with you by telling you what he/she is doing, relating past information or asking questions such as why, when and how? YES NO
6. Do you frequently need to talk loudly for your child to hear you? YES NO
7. Are you concerned about your child's hearing? YES NO
8. Do you think your child stutters? YES NO
9. Does your child always have a hoarse voice, sound like he/she has a cold or sound like he/she is talking through his/her nose (nasal)? YES NO
10. Do you have any concerns about your child's speech and language development? YES NO

If you answered **YES** to question #10, please explain: _____

