Speech Therapy Assessment Forms

Speech Therapy
Assessment Form

IDENTIFYING INFORMATION:

Patient Name: _____
Age: _____ Date of Birth: _____
Referred by: _____
Presenting complaint (unintelligible speech, dysfluency, voice problem):_____
_____
Relevant medical history: _____
Motor/ developmental history: _____
Social/ occupational history: _____
Address: _____
Phone: _____

ASSESSMENT INFORMATION:

ARTICULATION:

Conversation speech (sound errors, intelligibility): _____
Consistency of sound error: _____
Patters of sound errors (error type):_____
Stimulability of errors (whether correct sounds can be made)_____
_____

LANGUAGE:

Receptive language:_____
_____
Expressive language:_____
_____
Cognition:_____
_____
_____

SWALLOWING:

Relevant medical history:_____
Current feeding status:_____
Dietary limitations:_____
Cognitive status:_____
Significant oral motor findings:_____
_____
Gag reflex: _____

FLUENCY:

Type of dysfluency (repetitions, prolongation, silent pause etc.): _____

_____

Associated motor behavior (hand movement, eye blinking, forehead wrinkling etc.)

_____

Avoidance of sounds, words, or situations:_____

_____

Stimulability of fluent speech:_____

VOICE:

Quality (hoarse, aphonic, etc): _____

Pitch (too high, too low, etc): _____

Resonance (nasal, denasal, mixed): _____

Stimulability of improved voice: _____

Oral facial Examination (Face, Lips, tongue, hard, & Soft Palates etc.): _____

_____

_____

Voice improvement in A.M or P.M: _____

HEARING:

Type of hearing loss: _____

Hearing level (dB level): _____

Age of onset: _____ patient's age when loss was diagnosed._____

Age of wearing hearing aids: _____

Duration of wearing hearing aid (in whole day): _____

Previous intervention (therapy or educational placement, communication mode etc.)

_____

Patient's general health:_____

SUMMERY:

Diagnosis: _____

Frequency: _____ Prognosis:_____

RECOMMENDATIONS:

Suggestion to the client and / or caregivers: _____

_____

_____

Referral to other professionals: _____

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FAMILY HISTORY:

	Father	Mother
Name:	_____	_____
Age:	_____	_____
Education:	_____	_____
Profession:	_____	_____
Any Disability In the family:	_____	_____
Nature of Disability:	_____	_____
Any other detail:	_____	_____

SPECIFIC INFORMATION

A. EDUCATIONAL HISTORY

Does the child attend any school?

a. Yes
b. No

Which school child attends?

a. Special School
b. Normal School

Name of the school _____

In which grade / class child is studying? _____

Any Other: _____

HEARING & SPEECH / LANGUAGE INFORMATION

Child's Mother Tongue: _____
Language spoken at home: _____
Language spoken at school: _____
How child usually communicates?

a. Gestures
b. Signs
c. Single Words
d. Short Phrases
e. Sentences
f. Other: _____

Child's specific speech / language problem:

a. Omission
b. Addition
c. Distortion
d. Substitution
e. Other: _____

Does the child visit any of the professional?

a. Speech /language pathologist
b. Audiologist
c. Special Educationist
d. Other: _____

How child interacts with others?

a. Shy
b. Aggressive
c. Uncooperative
d. Other: _ _____

Other behavioral problem (if any): _____

Type of Hearing Loss:

a. Bilateral
b. Unilateral

Nature of hearing loss:

a. Pre lingual
b. Post lingual

Level of hearing loss (in dB)(if known): _____

Use of hearing aid

a. Always
b. Occasionally
c. Only in school
d. Never

Other Details: _____