CREATIVE SPEECH SOLUTIONS, LLC

Pediatric Therapy Center

MONTCLAIR SUMMER GROUP QUESTIONNAIRE

Date____________________

Name of child___________________________ Nickname/Name child goes by ________

Date of Birth________________ Age____________

Name of person completing form_____________________________

Relationship to child_______________________________________

Your comments will help us to best meet your child's therapeutic needs. Please use information you know about your child as well as goals/objectives from his/her IEP (if applicable). The more specific you can be the better so that we can address the areas that your child needs most.

Please describe your child's school setting (e.g., mainstream classroom, integrated preschool, self-contained classroom, ABA program). If your child has a shadow/aide at school, please indicate:____
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Does your child receive therapy services in or out of school (e.g., speech, occupational or physical therapy; tutoring/resource services)? If yes, please describe, including areas addressed (e.g., balance, coordination, expressive language, articulation, reading)________
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Please specifically describe your child's speech and expressive language ability (e.g., conversational, one word answers, 3 word phrases, hard to understand etc.)____________
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Please specifically describe your child's receptive language ability (e.g., can follow multi-step directions, has difficulty understanding linguistic concepts, gets easily distracted.)

Please describe any language/social challenges at home/school/in the community:

Please indicate your child's interests and favorite activities:

What do you feel are the most important skills for this child to work on during group?

Is there anything else you feel we should know about your child?______________________

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