



CREATIVE SPEECH SOLUTIONS, LLC

Pediatric Therapy Center

Virtual Camp PAL QUESTIONNAIRE

Date: _____
Name of child: _____ Nickname: _____
Date of Birth: _____ Age: _____
Name of person completing form: _____
Email: _____ Phone: _____

Please fill out the following questionnaire in order to assist us in grouping your child as well to better assist us in meeting his/her individual 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 typical (pre remote learning) school setting (e.g., mainstream classroom, integrated preschool, self-contained classroom, ABA program). If your child has a shadow/aide at school, please indicate: _____

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): _____

Please describe your child's expressive language ability (e.g., conversational, one-word answers, 3-word phrases etc.): _____

Please describe your child's receptive language ability (e.g., follows 1, 2, 3 step directions, responds to his name, understands 'who, what, where, why, when' questions):

Please describe your child's fine and gross motor skills and challenges; (e.g., pencil grasp, can they write letters/numbers, physical limitations, etc.):

Please describe any language/social challenges at in the home/school/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 Virtual Group Sessions?(please be specific and list at least 3): _____

If your child has been doing remote learning, how long can they attend for? _____

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