Mary Washington
PEDIATRIC THERAPY
a department of Mary Washington Hospital

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Speech Therapy Progress Update Questionnaire

Date:_____

Child's name:_____ Date of Birth: _____/ _____ / _____

Person filling out this form:_____ Relation to child:_____

Are there any changes to your address or phone number? ❑ Yes ❑ No
(If yes, please notify the receptionist of the changes) ❑ Yes ❑ No

Have there been any changes to your insurance information? (If yes, please notify the receptionist of the changes)

Current Physician: _____ Phone: _____

Any medical diagnoses? (Please list diagnosis and date received)

_____
_____
_____
_____

Any changes in medical history since the last evaluation? If yes, please explain.

_____
_____
_____
_____

List any other health care providers or specialists that your child is under the care of:

_____
_____
_____

Do you have any concerns regarding your child's hearing? ❑ Yes ❑ No

_____
_____
_____

Is your child currently receiving ST services at Mary Washington Pediatric Therapy? ❑ Yes ❑ No

If yes, what therapy progress have you observed (be specific)? _____

_____
_____
_____
_____
_____
_____
_____

Does your child receive any other types of services (OT, PT, ABA) and how often?

_____
_____
_____
_____

PLEASE CHECK ANY CURRENT CONCERNS:

❑ Speech Production ❑ Receptive Language ❑ Expressive Language ❑ Stuttering ❑ Voice Concerns
❑ Difficulty with transitions ❑ Difficulty Following directions ❑ Difficult to understand ❑ Difficult attending to tasks
❑ Difficulty communicating wants/needs ❑ Other:_____

What goals would you like to see achieved by your child during speech therapy?

_____
_____
_____
_____
_____
_____
_____

Other comments:

Thank you!