PHONOLOGY AND ARTICULATION
PARENT INPUT FORM

Student's Name: ______________________________________ Date: _______________________

Parent's Name: _______________________________________ Birth Date/Age: __________ / _________

Language spoken in the home: ____

Medical History: (i.e., premature, ear infections, tonsils & adenoids, allergies, a quiet baby, developmental milestones such as cooing, babbling, etc.) Explain ____

____

____

What are your concerns regarding your child's articulation skills? Please check all that apply.

_____ Child deletes sounds when speaking

_____ Child changes sounds when speaking

_____ Child distorts sounds when speaking

_____ Other concerns please explain ____

____

Is your child aware of his/her speech difficulty?______ Yes ______ No

Does your child appear to be frustrated by his/her speech difficulty?
_____ Never _____ Sometimes_____ Frequently_____Always

Does your child avoid speaking? _____ Never _____ Sometimes_____ Frequently _____Alway

Is it difficult to understand your child? _____ Never_____ Sometimes_____ Frequently _____Always

Is it difficult for others to understand your child?
Familiar people _____ Never _____ Sometimes_____ Frequently _____Always
Unfamiliar people _____ Never _____ Sometime _____ Frequently _____Always

Are there any situations that make it harder for you to ____

____

How does your child's speech difficulties affect him/her? _____________________________________

____

Comments:

____

Parent Signature Date