

Speech – Articulation Parent/Guardian Input Form

Child's Name: _____

Date: _____

1. Previous Services

Has your child received early intervention, speech therapy, or other services in the past?

Yes No If yes, please explain (where/when/for what concern):

2. Speech Concerns – Articulation of Sounds

What speech articulation concerns and/or errors do you hear in your child's speech?

(Check all that apply)

Leaves sounds out of words

Substitutes one sound for another

Distorts sounds (e.g., lisp)

Difficulty with specific sound(s): _____

Speech sounds immature for age

Speech is unclear overall

Not sure

Additional comments (optional): _____

3. Speech Intelligibility

How well is your child understood?

By family members:

Almost always

Most of the time

Sometimes

Rarely

By people who do not know your child well:

Almost always

Most of the time

Sometimes

Rarely

4. Impact on Communication

My child becomes frustrated when trying to speak

My child avoids certain speaking situations (e.g., reading aloud, talking in class, speaking with peers)

My child does not seem bothered by speech difficulties

Medical / Developmental Information

5. Oral–Motor / Structural History

Has your child had any concerns related to mouth or facial structure or oral-motor skills?

(e.g., cleft lip/palate, tongue-tie, dental issues, jaw concerns, chewing or swallowing difficulties)

Yes No If yes, please explain: _____

6. Hearing / Ear History

Do you have any concerns about your child's hearing?

Yes No If yes, please explain: _____

Has your child had frequent ear infections?

Yes No If yes, please explain: _____