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? ☐ Yes ☐ No

Does your child avoid speaking? ☐ Yes ☐ No

Is it difficult to understand your child? ☐ Yes ☐ No

Is it difficult for others to understand your child? ☐ Yes ☐ No

Familiar people ☐ Yes ☐ No

Unfamiliar people ☐ Yes ☐ No

Are there any situations that make it harder for you to understand your child? Please explain.

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

Comments: