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Clinique • Orthophonie

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Questionnaire for adults with a swallowing disorder

Here is a questionnaire that might seems long to complete but is essential to the assessment. It will help the speech and language pathologist understand the nature of the difficulties.

IDENTIFICATION

Client's name : Birth place **:**

Birth date : Age **:**

Complete address (with postal code):

Phone Home : Work : Cell. :

Email :

How did you find us? :
□ through the Ordre des Orthophonistes et Audiologistes du Québec
□ doctor's reference: _____
□ speech pathologist's reference : _____
□ dentist/orthodontist's reference : _____
□ other : _____

Person filling out the questionnaire :

SOCIAL HISTORY

With whom the child lives?

Type of relationship between parents :

Where are the parents from? Mother: Father:

For how long have the parents been in Québec: Mother: Father:

Mother's work? Father's work?

Describe the relationship between the child and his parents :

Brothers and sisters :

Name	Age	Gender	Same parents
_____	_____	☐ M ☐ F	☐ Yes ☐ No
_____	_____	☐ M ☐ F	☐ Yes ☐ No
_____	_____	☐ M ☐ F	☐ Yes ☐ No

What are the languages spoken at home?
Which language is mainly spoken at home?

What are the languages spoken at school?

In general, the child's schedule is : ☐ Free? ☐ Occupied?

In general, the parents' schedule is : ☐ Free? ☐ Occupied?

The atmosphere at home is : ☐ generally under pressure? ☐ generally relax? ☐ variable?

Tell us about your child's personality:

☐ lonely	☐ shy	☐ sociable	☐ intellectual	☐ active
☐ hyperactive	☐ calm	☐ confident	☐ aggressive	☐ impulsive
☐ stubborn	☐ easily frustrated	☐ perseverant	☐ absent-minded	☐ inattentive
☐ sensitive	☐ cheerful	☐ easily tired	☐ low self-esteem	☐ _____

ORTHODONTIC ASPECTS

Description of problem by client/parents :

Consequences :

Other persons in the family presenting that problem :

Name of orthodontist. : Since :

Treatment so far :

Futher treatment planned :

Last appointment : Next appointment :

MEDICAL ASPECTS

Previous medical treatment ☐ Name of Dr. :
Reason and date :

Previous speech treatment ☐ Name of speech pathologist :
Reason and date :
Results :

Allergies :
Traitement: When :
Results :

Asthma/Breathing disease :

Infections:
Frequent cold ☐ Sinusitis ☐ Amygdalites ☐
Pharyngitis ☐ Laryngitis ☐

Otitis/Ear problem :
Audition: Audiogram ☐ Date and results :

Severe diseases/Surgeries/Wounds :

Digestive disorders :

Orofacial pain ☐

Headaches ☐ Frequency :

Sensitive teeth ☐

Medication :

DEVELOPMENTAL ASPECTS

Language development :

Motor developement :

Psychologic health :

Alimentation:

School : Level :

How is it going concerning the learning abilities?

Difficulties :

Other particularities :

BREATHING ASPECTS

Breathing during the day:

☐ oral ☐ nasal ☐ both

Breathing by night:

☐ oral ☐ nasal ☐ both

Snoring ☐

Able to blow nose :

EATING ASPECTS

Difficulties to chew ☐

Drinks a lot during meals ☐

Chews gum ☐

Difficulties to swallow pills ☐

ORAL HABITS

Breast feeded ☐ Duration : Pacifier ☐ Duration :
Milk bottle ☐ Duration :

SUCKING (THUMB, FINGERS, CHEEK, OBJECTS, CLOTHES, LIPS, TONGUE, ETC.) ☐

Duration : Frequency : Intensity :

Stress factors :

Feelings associated :

LICKING OF THE LIPS ☐

Duration : Frequency : Intensity :

CHEWING LIPS, CHEEKS, OBJECTS ☐ **ONE SIDE L** ☐ **R** ☐ **BOTH SIDES** ☐

Duration : Frequency : Intensity :

BITING NAILS ☐

Duration : Frequency : Intensity :

EXTERNAL PRESSURE ON LOWER JAW ☐
EXTERNAL PRESSURE ON UPPER JAW ☐

Duration : Frequency : Intensity :

Questionnaire de Annie Bertrand M. Sc. (A), S-LP(c) & Mireille Delisle M.O.A., Orthophonistes
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MOTIVATION

From whom came the demand to consult in speech pathology?
☐ Yourself ☐ Your child ☐ Other :

How do you evaluate your motivation to participate to a speech therapy?
☐ intense ☐ moderate ☐ low ☐ absent

_____, orthophoniste # Date : _____