

Parent Checklist: Voice

Name _____ Date _____

Person completing this form _____

Return to _____ by _____

Your input will help us understand your child's speech skills. Please check the following items. Thank you.

My child	Yes	Sometimes	No
has a hoarse voice			
clears his/her throat frequently			
sounds nasal - talks through his/her nose			
sounds denasal - stuffed up			
speaks too quietly			
speaks too rapidly			
has pitch unusual for his/her age or sex			
speaks in a monotone			
has breaks in his/her voice			
is frustrated by his/her speech difficulty			
has a family member with similar difficulty			
has allergies			
has frequent ear infections			
is exposed to environmental factors like kerosene fumes, wood or cigarette smoke			
frequently yells or plays loud games (for example, car, gun or animal noises)			
participates in sports or activities (singing) where he/she uses his/her voice loudly			

Rate your concern for your child's voice.

Rate your concern for your child's communication skills.

None 0 1 2 3 A lot

Does your child's voice change during the day? _____

If so when is it better? _____

What other information do you think would be helpful for this evaluation?