ARTICULATION
Teacher Input Form

Student's Name:_____ **Date:**_____
Teacher's Name:_____ Birthdate/Age:_____/_____

What are your concerns regarding your student's articulation skills? Please check all that apply.
_____ Student deletes sounds when speaking
_____ Student changes sounds when speaking
_____ Student distorts sounds when speaking
_____ Other inappropriate use (explain)_____
_____

Is your student aware of his/her speech difficulty? _____ Yes _____No

Does your student appear to be frustrated by his/her speech difficulty?
_____ Never _____Sometimes _____Always

Does your student avoid speaking?
_____Never _____Sometimes _____Always

Have your student's parents expressed concerns regarding your student's articulation skills?
_____ Yes _____No

Is it difficult to understand you student? ____Never ____Sometimes ____Always

Is your student hard to understand?

_____ all of the time	_____ in context	_____ out of context
_____ most of the time	_____ in context	_____ out of context
_____ some of the time	_____ in context	_____ out of context

How do your student's articulation difficulties impact his/her reading, writing, or other academic skills? _____

_____

How do your student's articulation difficulties impact him/her socially and/or vocationally?

_____

_____

_____ _____
Teacher Signature Date

ARTICULATION
Parent Input Form

Student's Name:_____ **Date:**_____
Parent's Name:_____ Birthdate/Age: _____/_____

Medical History: (i.e. ear infections, tonsils & adenoids, allergies, developmental milestones such as cooing, babbling, quiet, 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 inappropriate use 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 _____Always

Does your child avoid speaking?
_____Never _____Sometimes _____Always

Is it difficult to understand your child?
_____Never _____Sometimes _____Always

Is your child hard to understand?

_____ all of the time	_____ in context	_____ out of context
_____ most of the time	_____ in context	_____ out of context
_____ some of the time	_____ in context	_____ out of context

How do your child's articulation difficulties impact him/her? _____
_____

Comments: _____

_____

_____ _____
Parent Signature Date

ARTICULATION
Student Input Form

Student's Name:_____ **Date:**_____
Parent's Name:_____ Birthdate/Age: _____/_____

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

What is your concern regarding your articulation skills? Please check all that apply.
_____ Delete sounds when speaking
_____ Change sounds when speaking
_____ Distort sounds when speaking
_____ Other inappropriate use. Explain: _____
_____

Do you think you have a speech difficulty? _____Yes _____No

Are you frustrated by your speech difficulty?
_____ Never _____Sometimes _____Always

Do you avoid speaking?
_____Never _____Sometimes _____Always

Are you told that you are difficult to understand?
_____Never _____Sometimes _____Always

Is it hard for people to understand you?

_____ all of the time	_____ in context	_____ out of context
_____ most of the time	_____ in context	_____ out of context
_____ some of the time	_____ in context	_____ out of context

How does your articulation difficulty impact you educationally? _____
_____

How does your articulation difficulty impact you socially and/or vocationally?_____
_____

Comments: _____

_____

_____ _____
Student Signature Date