**East Tennessee State University**



**Speech-Language-Hearing Center**

**P.O. Box 70643 ∙ Johnson City, TN 37614**

**Telephone: (423) 439-4355**

**FAX: (423) 439-4607**

Dear Parent or Guardian,

The enclosed packet of information has been sent to you to complete and return following the request for a child feeding evaluation at the ETSU Speech-Language-Hearing Center. Your child’s evaluation appointment will not be scheduled **until the completed information packet and the demographics have been returned and we have received a referral from your child’s primary care physician.** Once the packet is received, you will be contacted to schedule the appointment or if there are no available appointments at that time, your child will be put on a waiting list.

We do file insurance and if the insurance doesn’t cover our services we do have a sliding scale that you may apply for. If you wish to apply for the sliding scale please request the form, fill out the sliding scale form and send it back with proof of income. **If your insurance requires prior authorization, it is your responsibility to make sure that we have it before the first visit.**

If your child has had previous feeding evaluations, speech-language evaluations or therapy, a copy of the report(s) would be helpful. You may make arrangements to have them directly mailed to our clinic at the address above or you may bring them with you on the day of the appointment.

On the day of your child’s appointment, please park in a Lamb Hall Clinic (limited) space in front of the building or a faculty/staff or student space. **You may only park in handicap space if you have the federally approved handicap hangtag or handicap license plate, you may not park in “No Parking” spaces or time limited spaces (ex. 20 minute parking only).** When you check in, the clinic staff will give you a Temporary Parking Permit that you will have to take back to your vehicle before your child’s appointment or you can get a Permit at the Parking Office at 908 West Maple to avoid a parking ticket.

The ETSU Speech-Language Hearing Center is located in Lamb Hall on the 3rd floor, room 363 at the check-in window. If you need more detailed directions, please call the clinic office at (423) 439-4355.

Thank you for your interest in the ETSU Speech-Language-Hearing Center. Please do not hesitate to contact me if you have any questions or need additional information. We look forward to seeing you.

Sincerely,

Angela Rosenbalm A.A.S, CPS

Clinic Office Manager

Speech-Language-Hearing Clinic

East Tennessee State University

Speech-Language and Hearing Clinic

Box 70643

Johnson City, TN 37614-0643

Child Clinic

**Child Feeding History Questionnaire**

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Name of person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:

Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Number Street

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip Code

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1. **IDENTIFYING INFORMATION:**

Child for who the appointment is requested:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_\_\_\_\_\_\_\_Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State Zip Code

Telephone: (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **REFERRED BY:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (e.g., teacher, speech-language pathologist, audiologist, doctor)

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State Zip Code

1. **HOME AND FAMILY**

Mother’s age: \_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s age: \_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child lives with: Both Parents\_\_\_\_\_\_\_Father\_\_\_\_\_\_\_Mother\_\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_

If other than the natural parents or guardians, please give names and relationship:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the child adopted? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

If yes, at what age was the child adopted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brothers and Sisters:

Name: Age: Any feeding/communication problems?

1. **PREGNANCY, BIRTH, AND EARLY DEVELOPMENT:**

**Pregnancy:**

* 1. Length of pregnancy in Months:\_\_\_\_Number of pregnancy preceding this one:\_\_\_
	2. Mother’s health during pregnancy: (Please circle) good fair poor
	3. Any illnesses or accidents during pregnancy?: Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

If yes, please describe briefly:

* 1. Were any drugs/medications taken by the mother during pregnancy? Yes\_\_ No\_\_

If yes, please list medications taken:

* 1. Age of mother at child’s birth:\_\_\_\_\_\_\_\_ Age of father at child’s birth:\_\_\_\_\_\_\_\_
	2. Was there a blood (RH factor) incompatibility?: Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

**Birth**

1. Length of labor in hours:\_\_\_\_\_\_\_\_\_\_\_\_
2. Any unusual problems at birth (e.g., breech, Caesarian section)?: Yes\_\_\_\_No\_\_\_\_

If yes, please describe:

1. What drugs or anesthetics (if any) were used during labor and/or delivery?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did your child require oxygen?: Yes\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_
2. Was your child “blue” or jaundiced (yellow) at birth?: Yes\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_
3. Were there any injuries, scars, or deformities observed at birth?: Yes\_\_\_\_No\_\_\_\_

If yes, please describe:

1. Where was your child born (hospital, city, state):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Were there any problems immediately after birth or during the first two weeks of your child’s life? Yes\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

 **Early Development:**

1. Please check the box at which your child performed the following action (age in months)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Action** | **1-3** | **4-6** | **7-9** | **10-12** | **13-18** | **19-24** | **25-36** |
| Kicking, Squirming |  |  |  |  |  |  |  |
| Grasping Tightly |  |  |  |  |  |  |  |
| Flipping from Back to Belly |  |  |  |  |  |  |  |
| Sitting Alone |  |  |  |  |  |  |  |
| Belly Scooting/Creeping |  |  |  |  |  |  |  |
| Crawling |  |  |  |  |  |  |  |
| Standing Alone |  |  |  |  |  |  |  |
| Walking Alone |  |  |  |  |  |  |  |
| Running |  |  |  |  |  |  |  |
| Feeding Self |  |  |  |  |  |  |  |
| Dressing Self |  |  |  |  |  |  |  |
| Bladder Trained |  |  |  |  |  |  |  |
| Stool Trained |  |  |  |  |  |  |  |

1. **CHILD’S HEALTH**
	1. Name of your child’s Doctor or Pediatrician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City, State Zip Code

How long has your child been under this doctor’s care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Has your child had any of the following illnesses?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Illness** | **Age** | **Fever? Yes/No** | **Duration in Days** | **Was Child Hospitalized** |
| Chicken Pox |  |  |  |  |
| Diphtheria |  |  |  |  |
| Draining Ears |  |  |  |  |
| Ear Infections |  |  |  |  |
| Encephalitis |  |  |  |  |
| Epilepsy |  |  |  |  |
| Frequent Colds |  |  |  |  |
| Influenza |  |  |  |  |
| Measles |  |  |  |  |
| Meningitis |  |  |  |  |
| Pneumonia |  |  |  |  |
| Polio |  |  |  |  |
| Scarlet Fever/Scarletina |  |  |  |  |
| Sinus Infection |  |  |  |  |
| Tonsillitis |  |  |  |  |
| Whooping Cough |  |  |  |  |
| Other |  |  |  |  |

* 1. Has your child experienced high fevers?: Yes\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please explain briefly:

* 1. Please list any injuries or operations your child may have had. Please include tonsillectomy, adenoidectomy, or myringotomy (tubes in the ears), if applicable (Use back of this sheet if needed).

Injury/Operation Date Age

* 1. Does your child have any allergies? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes please list both **food** and **medication** he/she is allergic:

* 1. Is your child on any medications?: Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, what are they?

* 1. Does your child have any physical handicaps? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe below:

* 1. In general, how would you describe your child’s health? Good\_\_\_\_Fair\_\_\_\_Poor\_\_\_\_
	2. Is your child currently receiving any therapies?: Yes \_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_

If yes, what types (e.g., PT, OT, speech etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **FEEDING**
	1. When did feeding become a concern? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. What are the feeding concerns you have for your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. What previous feeding assessments/studies has your child had? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Has your child ever received therapy to address feeding before? Yes\_\_\_ No \_\_\_

If yes, please describe briefly:

* 1. How does your child receive most of his/her nutrition (e.g., by mouth, feeding

 tube)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If your child has a feeding tube please describe your child’s history with the feeding tube including why she/he received it, and when it was placed:*

*What type of tube does your child have?*

* *Nasogastric*
* *Gastrostomy*
* *Catheter*
* *Other*

*If your child has a gastrostomy tube please describe what kind (e.g., Button, Jejeunostomy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 6. Does your child have a history of reflux? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

 If yes, how has it been treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is a dietician working with your child?: Yes\_\_\_\_\_ No \_\_\_\_\_

If yes, who and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is your child followed by a GI doctor?: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, who and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Feeding History:**

1. Describe your child’s early feeding history (Please check if apply):
	* Breast-fed? How Long? Problems?
	* Bottle-fed? How Long? Problems?

If problems occurred, please describe briefly:

1. What formula(s) was/is your baby on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How did your baby tolerate formula? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. When did you introduce pureed foods (e.g., First Foods)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. How did your child do with pureed foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How did your child do with the transition to lumpy and solid foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. At what age did your child transition from bottle to cup? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. At what age did your child transition from baby food to solid foods? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Feeding Descriptions**

1. Please check if any of the following occur during eating/drinking:
	* coughing
	* gagging
	* throwing up
	* food coming out the nose
	* excessive burping
	* runny nose
	* watery eyes
	* complaints of pain

Please explain the foods or situations that describe the above checked behaviors:

1. Does your child seem to have more trouble with solids or liquids? \_\_\_\_\_\_\_\_\_\_\_\_
2. Does your child experience excessive drooling or spillage of food from his/her mouth?: Yes\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_
3. Does your child have favorite food tastes?: Yes \_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_

If yes, what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your child have favorite food textures?: Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

If yes, what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your child prefer food at a certain temperature (e.g., cold, warm, hot, room temperature)?: Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

**Feeding Routine:**

1. How often does your child eat and drink during the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Please describe what your child eats in a typical day:

Breakfast:

Lunch:

Dinner:

Snack(s):

1. How is the food prepared? (Check all that apply)
	* Regular liquid
	* Thick liquid
	* Commercial pureed baby First or Second Foods
	* Prepared in blender
	* Ground or commercial Third Foods
	* Mashed soft table foods
	* Regular table food (easy)
	* Regular table food (hard)
	* Other (please specify)
2. Which of these food types are easiest for your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Which of these food types are most difficult? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What do you use when feeding your child? (Check all that apply)
* Breast
* Fingers
* Spoon
* Fork
* Cup
* Bottle
* Straw
1. Which of the following can your child use independently? (Check all that apply)
* Fork
* Fingers
* Spoon
* Cup
* Bottle
* Straw
1. Where is your child fed (e.g., chair, booster seat, lap)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How long does it take to feed your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What is the average amount of food/liquid your child takes during that time? \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VII. Language Development:**

1. Please check the age at which your child performed the following actions (age in months)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Action** | **4-6** | **7-9** | **10-12** | **13-18** | **19-24** | **25-36** | **37-48** | **49-60** |
| Gurgling sounds  |  |  |  |  |  |  |  |  |
| Babbling (bababa-dadada) |  |  |  |  |  |  |  |  |
| **Action** | **4-6** | **7-9** | **10-12** | **13-18** | **19-24** | **25-36** | **37-48** | **49-60** |
| First Words |  |  |  |  |  |  |  |  |
| Two or more words together |  |  |  |  |  |  |  |  |
| Says his/her name |  |  |  |  |  |  |  |  |
| Naming 10-20 objects |  |  |  |  |  |  |  |  |
| Naming 10-20 actions |  |  |  |  |  |  |  |  |
| Asks “What,” “Why” question’s |  |  |  |  |  |  |  |  |