APPENDIX A

FLYER FOR PARTICIPANTS

|  |
| --- |
| RESEARCH STUDY: PARENTS OF CHILDREN WITH COMMUNICATION DELAYS AND DISORDERS |
| We are looking for volunteers to participate in a parent training program for children between the ages of 24-60 months. Parents will learn strategies on how to increase children’s’ communication skills. |

**RISKS:** There are no known risks associated with this study.

**BENEFITS:** Participants will receive thirty dollars in gift cards**.** This study may benefit others in the future by improving methods for the study of treating communication disorders in young children.

**WHERE:** The Center for Autism and Language Learning, Texas State University-San Marcos

**CONTACT:** Dr. Alisha Richmond-ar47@txstate.edu

**Appendix B**

**CASE HISTORY FORM**

Dear Parent/Guardian:

The information that is requested on this form is designed to provide a better understanding of your child's speech, language and hearing skills. This information will be very helpful for this study. Please fill out this form as fully and accurately as possible, and return the completed form to Dr. Alisha Richmond.

If there are any items that you do not fully understand, please circle the question. All information on this form will be treated confidentially and will not be released to any third parties.

Speech Language and Hearing Case History Form

### Confidential

**Identifying Information:**

|  |  |  |
| --- | --- | --- |
| Childs Name: | | Date: |
| Age: | Sex: | Birth Date: |
| Mother: | | Phone: |
| Father: | | Other Phone: |
| Address: | |
| Name of Person Completing This Form:  Relationship to Child: | | |

Nature of the Problem (Describe your child's problem as fully as possible):

**Family Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Mother's Occupation:  Education: Age:  Speech, Language or Learning Related Problems? | | | Father's Occupation:  Education: Age:  Speech, Language or Learning Related Problems? |
| Child lives with: both parents; father; mother; other | | | |
| Other adults living in the home: | | | |
| Who usually lakes care of your child? | | | |
| Children in the family: | | | |
| Name | Age | Sex | Speech, Language or Learning Related Problems? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Child's Development**

**Birth History**

|  |  |
| --- | --- |
| Mother's health during pregnancy: | |
| Pregnancy duration: | Birth weight: |
| Special Considerations: Prolonged Induced Breach Caesarean Twin (1st/2nd) Premature  Other | |
| Baby's health (color, jaundice, bruises, breathing problems, incubator, abnormalities): | |
| Feeding problems? | |

**Hearing:**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you think that your child has a hearing problem? If yes, explain: | | | |
| Has your child's hearing been tested? **Y/N** | |
| Findings: | | | |
| Tubes in ears: | Date inserted: | | Date removed: |

**Vision**

|  |  |
| --- | --- |
| Have child's eyes been examined? **Y/N** | Wear glasses? **Y/N** |
| Findings: | | |

**Motor Development**

|  |  |  |  |
| --- | --- | --- | --- |
| At what age did your child: | | | |
| Sit without support |  | Go up stairs one foot after the other |  |
| Crawl |  | Drink from cup, no help |  |
| Walk, holding on to furniture |  | Eat with utensils |  |
| Walk alone |  | Gain Bladder Control |  |
| Jump |  | Gain Bowel Control |  |
| Check any that apply: | | | |
| Trips easily |  | Climbs poorly |  |
| Afraid of climbing |  | No Fear |  |
| Clumsy with hands |  | Runs into things |  |
| Any other motor concerns? | | | |
| Any concerns with biting, drinking, chewing, or swallowing? (Please explain): | | | |
| Any food allergies/preferences? (Please explain): | | | |

**Health History**

|  |  |
| --- | --- |
| Current Medications: (Name, Dosage, Reason) | |
| Is child receiving any physical and/or occupational therapy now? **Y/N**  Why? | Where: |

**Medical Background**

Please indicate which of the following apply, age and duration:

|  |  |
| --- | --- |
| Adenoidenectomy |  |
| Allergies |  |
| Asthma |  |
| Blood Disease |  |
| Chicken pox |  |
| Chronic colds |  |
| Convulsions |  |
| Cross-eyed |  |
| Croup |  |
| Dental problems |  |
| Diphtheria |  |
| Drooling |  |
| Ear infections |  |
| Encephalitis |  |
| Headaches |  |
| Head injuries |  |
| High fevers |  |
| Influenza |  |
| Measles |  |
| Meningitis |  |
| Mouth breather |  |
| Mumps |  |
| Muscle disorder |  |
| Nerve disorder |  |
| Orthodontia |  |
| Pneumonia |  |
| Rheumatic fever |  |
| Scarlet fever |  |
| Tonsillectomy |  |
| Tonsillitis |  |
| Vision |  |
| Whooping cough |  |

If you checked any of the above or we did not list a condition you feel is important, please describe:

**Speech and Language**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| What were child's first words: Examples: | | | | | | | | Age: |
| First two-word phrases: Examples: | | | | | | | | Age: |
| How many words can your child say? 1-10 10-50 50-100 100-300 300-500 Over 500 | | | | | | | | |
| Give a few examples of phrases and/or sentences that your child typically uses at this time? | | | | | | | | |
| What percent of the time is the child's speech understood by: | | | | | | | | |
| Mother | Father | Brothers & Sisters | Friends | | Teachers | | Other relatives | |
| Does your child customarily communicate by use of: Gestures Pantomime Sounds One or two words Phrases Complete sentences | | | | | | | | |
| Does your child understand and/or speak another language other than English? If yes, explain: | | | | | | | | |
| Which is the predominant language at home? | | | | | | | | |
| Was there ever a time when our child's speech and language skills regressed or he/she stopped talking? When? Describe the circumstances: | | | | | | | | |
| How do your child's current speech and/or language concerns interfere with: | | | | | | | | |
| School setting: | | | | | | | | |
| Home environment: | | | | | | | | |
| Interpersonal Relationships (Social Skills)? (e.g., playing with other children) | | | | | | | | |
| Have speech and language skills been evaluated before? | | | | When? | | Where? | | |
| Did the evaluation lead to any treatment? | | | | When? | | Where? | | |

**Psychological and Neurological Development**

|  |  |  |
| --- | --- | --- |
| Has your child had a psychological exam? | When? | For what reason? |
| Has you child had a neurological exam? | When? | For what reason? |

Please indicate which of the following apply, age and duration:

|  |  |
| --- | --- |
| Nervousness |  |
| Aggressive |  |
| Annoyed by loud sounds |  |
| Bedwetting |  |
| Easily upset |  |
| Excessive shyness |  |
| Fearful of new situations,  strangers or sitters |  |
| Head banging |  |
| Hurts self |  |
| Hyperactive |  |
| Nightmares |  |
| Perseverative behavior (doing  things over and over) |  |
| Persistent habits (nail biting,  thumb sucking, nose picking) |  |
| Restless |  |
| Restless |  |
| Rock or roll |  |
| Sad |  |
| Sensitive to being touched |  |
| Short attention span |  |
| Sleeplessness |  |
| Staring at lights or objects |  |
| Temper tantrums |  |
| Tics |  |
| Withdrawn |  |

|  |
| --- |
| **How are these concerns manifested at home?** |
| **At school?** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Schools attended (including preschool): | | Grades: | Dates: | |
|  | |  |  | |
|  | |  |  | |
|  | |  |  | |
| Grades repeated | | | | |
| Child's attitude about current school program: | | | | |
| Specific concerns about current school program: | | | | |
| Special services (e.g., tutoring) received at school: | | | | |
| Who provides? | What subjects? | | | How often? |
| Special services (e.g., tutoring) received privately: | | | | |
| Who provides?  Address:  Telephone: | What subjects? | | | How often? |

**Educational Development**

**APPENDIX C**

**CLINIC VIDEO OBSERVATION INSTRUCTIONS**

**Instructions for parents during video recording**

This clinic observation videotaping will demonstrate how you and child interact during activities.

I would like to see the two of you involved in three specific activities, putting on shoes, playing, and book reading.

I will let you when you should move on to the next activity. Each activity should last between 5-10 minutes.

The videographers are instructed not to speak or interact while they are recording, so that the interaction between you and your child can be as natural as possible.

Are you ready? Ok first, I would like for you play with the toys in that are located in the room as you would on any given day.

Next, I would like for you to read a book with your child. You can choose any of the books in this basket.

Now, I want you to take off your child’s shoes and then put them back on.

Thanks we are now done with this videotaping activity.

**APPENDIX D**

**SYSTEMATIC HOME VIDEO OBSERVATION INSTRUCTIONS**

**Instructions for parents during video recording**

This home observation videotape will demonstrate how you interact with your child during the day.

We would like to see the two of you involved in 3-5 activities from at least two of the categories below. Once you complete the two of the categories, you can choose any other activities that you normally participate in daily.

We will be recording for one hour. The videographers are instructed not to speak or interact while they are recording, so that the interaction between you and your child can be as natural as possible.

|  |  |
| --- | --- |
| **Category: Activities with Toys**  **Activity Choices**  Blocks, Puzzles, Sand box, Playdough, Cars and Trucks,  Ball Games, Baby Dolls | **Category: Social Games**  **Activity Choices**  Peek-a-boo, Rough and Tumble, Songs & Rhymes |
| **Category: Activities with Food**  **Activity Choices**  Preparation, Eating, Cleanup | **Category: Daily Living Activities**  **Activity Choices**  Dressing, Diaper Change, Bath, Washing Hands, Brushing Teeth |
| **Category: Activities with Books**  **Activity Choices**  **Picture Books, Telephone Books, Cook books, etc.** | **Category: Household Tasks**  **Activity Choices**  Mailbox, Laundry, Care for Pets, Plants, etc. |

**APPENDIX E**

**QUESTIONS FOR HOME OBSERVATIONS**

**What activities does your child enjoy the most?**

**What daily activities does your child enjoy the least?**

**When do you and your child spend the most time together? What are you doing?**

**When you are speaking with your child, are you usually face to face or far apart?**

**When is your child the most cooperative?**

**When is your child the least cooperative?**

**What frightens your child?**

**How can you tell if your child is happy?**

**How can you tell if your child is sad?**

**What family member does your child interact with the most? For example, you can say, “\_\_\_\_\_\_ (child’s name) mainly plays and interacts with his sister.”**

**Do you believe that a child being quiet is a form of respect?**

**Which of the following statements are how you view your child learning to communicate?**

**My child learns more through my actions than what I say.**

**My child learns more through the words that I use than what I do.**

**My child learns equally as much from the words that I use and how I act**

**I expect my child to be obedient.**

**An example of my child being obedient is when he/she:**

**When my child does not understand something that I say, I usually:**

1. **repeat what I just said**
2. **say what I mean with less words**
3. **Nothing I just show him/her what to do**
4. **Nothing I just move on to another subject.**

**I believe that I \_\_\_\_\_\_\_\_\_ understand what my child’s intends to say or do.**

1. **Always**
2. **Usually**
3. **never**

**When you were growing up were your raised to speak your mind at all times or consider the other person’s feelings? Do you plan to raise your child the same way?**

**What are your hopes and dreams for your child?**

**How does your child participate in:**

**Mealtime**

**Bath time**

**Dressing**

**What would you like to learn about your child?**

**APPENDIX F**

**PARENT FIDELITY QUESTIONS FOR HOME SESSIONS**

**Please check the appropriate box based on your therapy time today.**

|  |  |  |
| --- | --- | --- |
| **Statement** | **Agree** | **Disagree** |
| **I was able to use the strategy** |  |  |
| **I was able to interact with my child for 30 minutes** |  |  |
| **I feel that the modules helped me understand how to use the strategy** |  |  |
| **I need more information on how to \_\_\_\_\_\_\_\_\_** |  |  |
| **I think my child enjoyed the activity today** |  |  |
| **I will try to use this strategy in another activity** |  |  |

**Major concerns:**

**Highlights of session:**

**APPENDIX G**

**POST TREATMENT SOCIAL VALIDITY QUESTIONS FOR PARENTS**

**Thank you once again for participating in this study. We would like to ask you some questions concerning how you feel about this type of parent training model.**

**In your opinion what were some of the benefits to participating in this training?**

**What were some of your overall concerns?**

**What did you like the most about online training modules?**

**What did you like the least about the online training modules?**

**What did you like the most about the videoconferencing sessions?**

**What did you like the least about the videoconferencing sessions?**

**What are your thoughts on the online feedback sessions?**

**Would you recommend this training to other parents? Why or Why not?**