Therapist Questionnaire

Name_____ Date_____

The following questions pertain to evaluations.

1. Do you feel comfortable performing ***Fluency*** evaluations? Yes/No

   If not, would you be willing to learn or refresh your memory? Yes/No

2. Do you feel comfortable performing ***Feeding*** evaluations? Yes/No

   If not, would you be willing to learn or refresh your memory? Yes/No

3. Do you feel comfortable performing ***PROMPT (children)*** evaluations? Yes/No

   If not, would you be willing to learn or refresh your memory? Yes/No

4. Do you feel comfortable performing ***Motor Planning (adult)*** evaluations? Yes/No

   If not, would you be willing to learn or refresh your memory? Yes/No

5. Do you feel comfortable performing ***Articulation*** evaluations? Yes/No

   If not, would you be willing to learn or refresh your memory? Yes/No

6. Do you feel comfortable performing ***Language- expressive/ receptive*** evaluations? Yes/No

   If not, would you be willing to learn or refresh your memory? Yes/No

7. Do you feel comfortable performing ***Aud. Processing*** evaluations? Yes/No

   If not, would you be willing to learn or refresh your memory? Yes/No

8. Do you feel comfortable performing ***Augmentative Communication*** evaluations? Yes/No

   If not, would you be willing to learn or refresh your memory? Yes/No

9. Do you feel comfortable performing ***Voice*** evaluations? Yes/No

   If not, would you be willing to learn or refresh your memory? Yes/No

10. Do you feel comfortable performing ***Accent Reduction*** evaluations? Yes/No

    If not, would you be willing to learn or refresh your memory? Yes/No

11. Do you feel comfortable performing ***Stroke*** evaluations? Yes/No
    If not, would you be willing to learn or refresh your memory? Yes/No

The following questions pertain to therapy sessions.

12. Do you feel comfortable performing ***Fluency*** therapy? Yes/No

13. Do you feel comfortable performing ***Feeding*** therapy? Yes/No

14. Do you feel comfortable performing ***PROMPT (children)*** therapy? Yes/No

15. Do you feel comfortable performing ***Motor Planning (child or adult***) therapy? Yes/No

16. Do you feel comfortable performing ***Articulation*** therapy? Yes/No

17. Do you feel comfortable performing ***Language- expressive/ receptive*** therapy? Yes/No

18. Do you feel comfortable performing ***Aud. Processing*** therapy? Yes/No

19. Do you feel comfortable performing ***Augmentative Communication*** therapy? Yes/No

20. Do you feel comfortable performing ***Voice*** therapy? Yes/No

21. Do you feel comfortable performing ***Accent Reduction*** therapy? Yes/No

22. Do you feel comfortable performing ***Word finding, therapy associated with CVA/TBI*** therapy? Yes/No

23. Out of the above questions answered no, are you interested in learning in expanding your area of expertise? Please explain.

24. What TESTS are you familiar with (please list):

25. Do you have any other strengths? Please list.

26. Do you have any other weaknesses? Please list