

BUFFALO MODEL QUESTIONNAIRE - REVISED

Simplified Child Form

Child Name:		Date:
Age:	DOB:	Filled in by:

Please indicate if you are currently receiving or have received any of the services and number of years:

Auditory training? YES ☐ _____ years NO ☐	Speech therapy? YES ☐ _____ years NO ☐	Phonological awareness training? YES ☐ _____ years NO ☐
Special phonics training? YES ☐ _____ years NO ☐	Special help with reading? YES ☐ _____ years NO ☐	Sensory-integration training? YES ☐ _____ years NO ☐

Please (✓) mark ‘YES’ if the statement applies to you or “NO” if it not a problem.

DEC	
My child has a problem saying speech sounds	YES ☐ NO ☐
My child has a problem understanding language	YES ☐ NO ☐
My child has a problem understanding spoken instructions	YES ☐ NO ☐
My child has a problem reading aloud	YES ☐ NO ☐
My child has a problem with phonics	YES ☐ NO ☐
My child has a problem with spelling	YES ☐ NO ☐
My child responds slowly/delayed to spoken language	YES ☐ NO ☐
My child has a problem learning foreign language	YES ☐ NO ☐ Never attempted foreign language learning ☐
My child speaks slowly	YES ☐ NO ☐
NOI	
My child is hypersensitive to noise	YES ☐ NO ☐
My child is distracted by noise	YES ☐ NO ☐
My child struggles to understand speech in noise	YES ☐ NO ☐
My child is noisy/makes more noises in comparison to their peers	YES ☐ NO ☐
MEM	
My child responds quickly, at times	YES ☐ NO ☐
My child frequently interrupts others talking	YES ☐ NO ☐
My child has a problem with reading comprehension	YES ☐ NO ☐
My child speaks quickly	YES ☐ NO ☐
My child forgets things they have been told	YES ☐ NO ☐
My child has a problem remembering spoken instructions	YES ☐ NO ☐
VAR	
My child has a problem paying attention	YES ☐ NO ☐
My child has a problem using language	YES ☐ NO ☐
My child has ADHD/ADD	YES ☐ NO ☐
My child has anxiety (e.g., new situations)	YES ☐ NO ☐

INT	
My child has extremely poor handwriting	YES ☐ NO ☐
My child has a problem integrating auditory and visual info	YES ☐ NO ☐
My child has significant reading/spelling difficulties	YES ☐ NO ☐
My child has significant visual perception difficulties	YES ☐ NO ☐
My child sometimes has very long response delays	YES ☐ NO ☐
My child has Dyslexia	YES ☐ NO ☐
ORG	
My child has a problem keeping things in organized	YES ☐ NO ☐
My child has a problem sequencing verbal items/information	YES ☐ NO ☐
My child is messy/tends to lose things	YES ☐ NO ☐
APD	
My child has a history of ear infections / ear fluid as a child	YES ☐ NO ☐
My child has a problem understanding what is said	YES ☐ NO ☐
My child has a learning disability	YES ☐ NO ☐
My child has a problem following spoken instructions	YES ☐ NO ☐
My child has an intellectual disability	YES ☐ NO ☐
My child has had a head injury	YES ☐ NO ☐
My child has Autism or a related problem	YES ☐ NO ☐
GEN	
My child is hypersensitive to touch	YES ☐ NO ☐
My child has a problem maintaining eye contact with a speaker	YES ☐ NO ☐
My child has a problem with long-term memory	YES ☐ NO ☐
My child has a psychological problem	YES ☐ NO ☐
My child has a behavior problem	YES ☐ NO ☐
My child has a problem coordinating body movements	YES ☐ NO ☐
My child may have allergies	YES ☐ NO ☐
My child has a problem learning math concepts	YES ☐ NO ☐
My child has a hearing problem	YES ☐ NO ☐

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/9	(/4)	(/6)	(/4)	/14	/6	/3	/7	/39	(/9)