Speech Therapy – Fluency Supplement

Patient Name: _____

DOB: _____

*Depending on your child's age, some questions may not be applicable.

Concerns

1. Describe your child's speech.

   _____
   _____

2. When did your child first start stuttering?

   _____
   _____

3. Were there any signs or developmental changes observed in your child's life when he/she first began stuttering? If so, please describe.

   _____
   _____

4. Has your child's stuttering changed since it first begun? If so, describe.

   _____
   _____

5. Did you take any steps to address your concerns once they arose (i.e., past assessments, therapy)?

   _____
   _____

6. Please make an estimate as to how often your child currently stutters (percentage).

   _____
   _____

7. Is there a history of a speech and/or language disorder (stuttering or speech sound problems) on either side of the family?

   _____
   _____

8. What you have done or others done to help your child stutter less? Please explain. Did someone tell you about these strategies?

_____
_____

9. Please list anything that you have tried to reduce your child's stuttering. What were the results?

_____
_____

10. Does your child demonstrate any of the following:

-Awareness of stuttering _____
-Physical tension during stuttering _____
-Frustration when speaking _____
-Says that he/she "can't talk" _____
-Eye blinking, looking away, facial grimaces, etc _____

11. Has your child ever been teased for stuttering? Yes No

12. Has your child ever discussed/talked about his/her speaking difficulties with you? Yes No

13. Rate how often your child is able to speak fluently in the following situations (circle one in each column):

-At home	Always	Almost always	Sometimes	Rarely	Never
-At school	Always	Almost always	Sometimes	Rarely	Never
-In new situations	Always	Almost always	Sometimes	Rarely	Never

14. How does your child's stuttering affect the following:

-Academic performance _____
_____
-Participation in school activities_____
_____
-Interaction with other peers _____
_____
-Interaction with other family members_____
_____
-Willingness to talk_____
_____
-Self-esteem or attitude toward self_____
_____

15. How often do the following behaviors occur? (Circle one in each column).

-Inattentiveness	Always	Almost always	Sometimes	Rarely	Never
-Hyperactivity	Always	Almost always	Sometimes	Rarely	Never
-Nervousness	Always	Almost always	Sometimes	Rarely	Never
-Sensitivity	Always	Almost always	Sometimes	Rarely	Never

-Perfectionism	Always	Almost always	Sometimes	Rarely	Never
-Excitability	Always	Almost always	Sometimes	Rarely	Never
-Frustration	Always	Almost always	Sometimes	Rarely	Never
-Strong fears	Always	Almost always	Sometimes	Rarely	Never
-Competitiveness	Always	Almost always	Sometimes	Rarely	Never
-Excessive neatness	Always	Almost always	Sometimes	Rarely	Never
-Excessive shyness	Always	Almost always	Sometimes	Rarely	Never
-Lack of confidence	Always	Almost always	Sometimes	Rarely	Never

Learning Style:

1. What are specific communication situations that are most challenging for your child?

   _____

   _____

2. How does your child learn best? (Reading, Listening, Demonstration, Pictures)

   _____

   _____

3. How do you learn best? (Reading, Listening, Demonstration, Pictures)

   _____

   _____

4. What are your child's favorite toys/activities that will be helpful for them to feel comfortable during the evaluation?

   _____

   _____

5. Is there anything else you would like to share with us?

   _____

   _____

Thank you for taking the time to complete this form.
Your contribution to this evaluation process is greatly appreciated and valued.
We look forward to meeting you. ☺