

TRAFFORD SPEECH, LANGUAGE & LITERACY SERVICES, INC.

Fluency/Stuttering Intake

Demographics

Name: _____

Date of Birth: _____ Age: _____ Gender: M / F

Home Address: _____ Primary Phone: _____

City, State, Zip _____ Primary EMail: _____

Parent(s) / Guardian(s)

Mother: _____ Day Phone: _____

Address (if different from above): _____

Father: _____ Day Phone: _____

Address (if different from above): _____

Other People in the Household:

Name Age Relationship

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TRAFFORD SPEECH, LANGUAGE & LITERACY SERVICES, INC.

2

Background

Referred by: _____

Reason for Referral: _____

Is there a family history of persistent stuttering? Y / N

If so, explain: _____

Is there a family history of recovered stuttering? Y / N

If so, explain: _____

How long has it been since the child started stuttering? _____

How has the stuttering changed (if at all) since it first started? _____

Which of the following behaviors do you hear/see your child demonstrating?

- Repeating short phrases (e.g., “I want, I want, I want juice.”)
- Repeating whole words (e.g., “Can can can I have some?” or “When, when, when is it?”)
- Starting to talk and revising what they want to say (e.g., “My dad, my mom, my family went to the park.”)
- Repeating the initial sounds of words (e.g., “C- Can I go?” or “S- S- Sing a song.”)
- Prolonging or stretching out sounds (e.g., “Mmmmy name” or “Siiiiister”)
- Blocking on sounds (e.g., “- - - - - I like ice cream” or “Listen - - - - - to me”)
- Extra words or fillers (e.g., um, uh, like)

Has your child ever demonstrated any . . .

- awareness of stuttering? physical tension during stuttering?
- frustration about speaking? complaints that they “can’t talk”?

Describe: _____

TRAFFORD SPEECH, LANGUAGE & LITERACY SERVICES, INC.

3

Has your child ever been teased about stuttering? Y / N

If yes, explain: _____

Has your child ever discussed his/her stuttering with you? Y / N

If yes, explain: _____

Are there situations where your child seems to stutter less? Y / N

If yes, explain: _____

Is English the only language your child uses? Y / N

If no, what other language does your child use? _____

At what age did your child start learning/speaking this language?

At what age did your child start learning/speaking English?

Medical and Developmental History

Was there anything remarkable about the mother's health during pregnancy or delivery?

Y / N

If yes, explain: _____

Was there anything remarkable about your child's condition at birth? Y / N

If yes, explain: _____

TRAFFORD SPEECH, LANGUAGE & LITERACY SERVICES, INC.

Does your child have any current health or medical concerns? Y / N

If yes, explain: _____

Is your child currently taking any medication? Y / N

If yes, what medication(s)? _____

Does your child have any allergies? Y / N

If yes, describe: _____

Does your child have developmental concerns? Y / N

If yes, check any of the following concerns that apply:

- Learning disability Cognitive impairment Behavior
 Attention/focusing Peer interactions Other

Describe the concerns in greater detail here, if necessary: _____

Has your child's hearing ever been tested? Y / N

If yes, what were the results? _____

How often do the following behaviors occur? Please circle one per item. (O = often, S = sometimes, N = never)

Inattentiveness	O	S	N	Frustration	O	S	N
Hyperactivity	O	S	N	Strong Fears	O	S	N
Nervousness	O	S	N	Excessive Neatness	O	S	N
Sensitivity	O	S	N	Excessive Shyness	O	S	N
Perfectionism	O	S	N	Lack of Confidence	O	S	N
Excitability	O	S	N	Competitiveness	O	S	N

TRAFFORD SPEECH, LANGUAGE & LITERACY SERVICES, INC.

How would you describe your child's overall temperament?

Stuttering/Speech/Language

Has your child previously been assessed for speech/language concerns? Y / N

If yes, describe: _____

Has your child received any prior speech/language therapy? Y / N

If yes, where? _____ By whom? _____

For how long? _____ Treatment focus: _____

Treatment results: _____

Have any other family members had speech/language treatment? Y / N

If yes, indicate the person's relationship to your child and the nature of the problem. _____

Rate how often your child is able to speak fluently in the following situations (check one per column):

	At Home	At School	In New Situations
Always			
Almost Always			
Sometimes			
Rarely			
Never			

TRAFFORD SPEECH, LANGUAGE & LITERACY SERVICES, INC.

6

How does your child's stuttering affect his or her . . .
academic performance? _____

participation in school activities? _____

interaction with other children? _____

interaction with family members? _____

willingness to talk and communicate? _____

self-
esteem or attitude toward self? _____

What do other family members do when they hear your child stutter?

What do you think will help your family manage the stuttering better?

Has the teacher noticed your child's stuttering?

- No
- Yes (and he or she approached the family with concerns)
- Yes (after being asked directly by the family)

Does your child currently receive treatment for stuttering? Y / N

If yes, where? _____

What goals/outcomes do you have for the child in therapy?

What else do you think we should know about your child (e.g., hobbies, interests, social skills)?

TRAFFORD SPEECH, LANGUAGE & LITERACY SERVICES, INC.

WAIVER/INFORMATION SHARING

By Signing this form, I give permission for my child's doctor, teacher, other care providers to share information with professional affiliates of Trafford Speech, Language and Literacy Services, Inc. I also understand that I am responsible for payment at the time of service.

Signature

Date

I give permission to have my child photographed or videotaped for:

_____ office use only;

_____ for office and possible advertisement/publication

_____ I do NOT give permission to have child photographed or videotaped for any other purpose than therapy related
