FONTBONNE UNIVERSITY

Department of Communication Disorders and Deaf Education

Eardley Family Clinic for Speech, Language and Hearing
6800 Wydown Boulevard, St. Louis, MO 63105-3098
(314) 889-1407
(314) 719-8016 Fax

You have requested a speech/language evaluation or therapy. Attached you will find a case history form. Answer the questions as fully and accurately as possible. If you have an IEP or diagnostic report from another institution, please attach a copy. This information will assist the clinic staff in planning and providing for your evaluation or therapy.

Return all forms to the speech clinic as soon as possible. We will call you to schedule an appointment. All evaluations and therapy sessions are conducted by graduate students under the direct supervision of a faculty member or supervisor. All faculty members and supervisors have valid Missouri licenses and ASHA certification.

We offer speech/language evaluations and speech language augmentative communication evaluations as well as therapy for all types of communication disorders. Evaluations are needed if there is no current evaluation or assessment by an ASHA certified speech pathologist.

Individual therapy is offered for all ages. This therapy is typically provided two days a week
(Mon & Wed or Tues & Thurs) for one hour each day.

Developmental Language Group (DLG) – This is a group of 6-8 children ages 2-5. We have 3 or 4 clinicians who work within the group. The group runs in the fall, spring and summer, 4 mornings a week, for 2 hours each morning usually form 9:00-11:00 AM.

We also have communication groups for individuals with Aphasia.

There are no fees for evaluations or therapy services.

Students, faculty, staff, and persons served in the program's clinic are treated in a nondiscriminatory manner-that is, without regard to race, color, religion, sex, national origin, participation restriction, age, sexual orientation, or status as a parent. The institution and program comply with all applicable laws, regulations, and executive orders pertaining thereto.

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Stuttering Case History Form – Adult & Adolescent

Date: ______________________
Name: ____
Address: _____________________________________Tel:________________________
____
Date of birth: ____________________________ Place of birth:____________________
Social Security #:_________________________ Referring physician: ________________
Sex: _____________ Marital status: _____________
Educational Level: __________________________ Occupation: ____________________
Employed by: ____
Referred to this Center by: ____
Name of spouse/nearest relative: ____
Address: ______________________________________ Tel: ______________________
____

History of Stuttering

Are there other individuals in your family background or immediate family who stutter?
____
Give approximate age at which your stuttering was first noticed. __________________
Who first noticed or mentioned your stuttering? _______________________________
In what situation did this occur? ____
____
Describe any situations or conditions that you associate with the onset of stuttering.
____
____
What were the first signs of stuttering? (If you don't remember, you might ask parents or siblings.)____
____
____
Was the stuttering always the same or did it occur in several different ways?
____
If the stuttering occurred in different ways, how were they different from one another?
____
____
Did the first blocks seem to be located in the tongue? Lips? Chest? Diaphragm? Throat? (Circle your answer.)
Approximately how long did each block (on one word) seem to last? ________________
Was the stuttering easy or was there force at the time when the stuttering was first noticed? ____
Were the words that were stuttered at the beginning of sentences, or were they scattered throughout the sentence being said? ____

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When stuttering first began, was there any avoidance of speaking because of it? Give examples, if any. ____

____

At the time when stuttering was first noticed, what was your reaction?
(Check all that apply.)
Awareness that speech was different? ___ Indifference to it? ___ Other?___
Surprise? ___ Anger or frustration? ___
Fear of stuttering again? ___ Shame? ___
What attempts have been made to treat the stuttering problem? ___________________

____

____

Development of Stuttering

Since the onset, have there been any changes in stuttering symptoms?
(Check all that apply.)
Increase in number of repetitions per word ___
Change in amount of force used (Increased?) ___ (Decreased) ___
Increase in amount of stuttering ___
Increase in length of block ___
Periods of no stuttering ___
More precise in speech attempts ___
Lowered voice loudness ___
Slower rate of speech ___
Change in location of force when stuttering (if force is present) ___
Looking away from listener ___
Describe any that apply____

____

Were there any periods (weeks/months) when the stuttering disappeared? ____________

____

Were there any periods (weeks/months) when stuttering increased? ________________

____

Can you give an explanation for these “worse” periods? __________________________

____

Current Stuttering

Are there any situations that are particularly difficult? If so, please describe. __________

____

____

List any situations that never cause difficulty. _________________________________

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Answer the following "yes" or "no" as they apply to your stuttering.
Do you stutter when you-

Talk to young children?	___	Recite memorized material?	___
Say your name?	___	Ask questions?	___
Answer direct questions?	___	Talk to strangers?	___
Talk to adults, superiors at work, teachers?	___	Speak when tired?	___
Use new words that are unfamiliar?	___	Speak when excited?	___
Use the telephone?	___	Talk to family members?	___
Read aloud?	___	Talk to friends?	___

Do you feel stuttering interferes with your career? ___ Social relationships? ___
Success in school? ___ Success on the job? ___ Daily life? ___
Do you know any stutterers? ___ Describe your relationship with them. _______________
____
____
Describe what your stuttering currently looks and sounds like. ______________________
____
____
____

Medical Development and Family History

If possible, please describe your mother's health during pregnancy and/or your birth history (i.e., complications). ____
____
____
Describe any development problems during infancy or early childhood (i.e., late in walking, feeding problems, food allergies, late in talking). __________________________
____
____
Are you: Right-handed? ___ Left-handed? ___ Both? ___ Is there evidence of visual, artistic abilities in your family? ____
____
Were you sensitive as a child? ___ Would you describe yourself as sensitive now? ___
List any significant illnesses, injuries, and operations:

Name	Date	Fever	Complications	Treatment	Physician's Name

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List all present disabilities.

Any chronic illnesses, allergies, or physical conditions?

Is your vision normal?   Hearing normal?

List any medications you take regularly or are taking currently.

Describe any learning or reading problems you experienced as a child or are currently experiencing.

Do any members of your family have speech or language problems or learning disabilities? If so, describe.

Social History

Hobbies
Leisure time activities

Describe any previous therapy you have participated in to aid your fluency. When? Where? With whom? For how long? Outcome?

Add anything else you would like to include and think might be important.

If, in order to help you, it is appropriate to send reports to other agencies or professional persons, or to contact other agencies or professional persons for additional information, please indicate your permission by signing below.

I authorize and request (fill in name of clinician or clinic) to obtain and/or exchange pertinent medical/educational information. I understand that all information will be kept confidential.
Signed: __________________________

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Date: ___________________________

If signed by person other than client, please state name and capacity of that person:

____

____

All information is for the confidential use of the Fontbonne University Speech/Language Clinic staff only.