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.

Case History Form for Child/Preteen—Fluency

Date: _____

Child's name: _____ Date of birth: _____ Age: _____

Street Address: _____ Home phone: _____

City: _____ State: _____ Zip Code: _____

Child lives with: Parents _____ Other (please specify) _____

Referred by: _____

Teacher's name: _____

School: _____ Grade placement: _____

Name of person completing this form: _____

FAMILY

Father's name: _____ Age: _____

Occupation: _____ Employer: _____

Telephone: (w) _____ Cell phone: _____

email address: _____

Mother's name: _____ Age: _____

Occupation: _____ Employer: _____

Telephone: (w) _____ Cell phone: _____

email address: _____

Name(s) of Brothers and/or Sisters Age (list below)

ONSET OF STUTTERING

Approximate age at which stuttering was first noticed _____

Who first noticed or mentioned the stuttering? _____

In what situation was the stuttering first noticed? _____

Describe any situations or conditions that might be associated with the onset of stuttering _____

_____

_____

Under what circumstances did the stuttering occur after the initial onset? _____

_____

What were the first signs of stuttering? (Check all that apply):

a. Repetitions of the whole word (boy-boy-boy) _____
b. Repetitions of the first letter of a word (b-b-boy) _____
c. Repetitions of the first syllable of words (ca-ca-cat) _____
d. Complete blocks on the first letter of words (b. . oy) _____
e. Prolongations of the vowel (caaaaaaaat) _____
f. Visible attempt to speak but no sound forthcoming _____

Was the stuttering always the same, or did it occur in several different ways? _____

_____

If it occurred in different ways, how were they different from one another? Describe.

_____

Was the stuttering easy, or was there force at the time when stuttering was first noticed? _____

_____

Were the words that were stuttered at the beginning of sentences, or were they scattered

throughout the sentence being spoken? _____

When stuttering first began, was there any avoidance of speaking as a result? Give examples, if any.

_____

_____

At the time when stuttering began, what was the child's reaction?

Awareness that speech was different _____ Surprise _____ Indifference _____

Anger and/or frustration _____ Fear of stuttering again _____ Shame _____

Other (describe) _____

What attempts have been made to treat the stuttering problem (either formally or informally)?

_____

_____

Does the child have speech sound pronunciation problems in addition to stuttering? If so, please describe _____

_____

DEVELOPMENT OF STUTTERING

Since the onset of stuttering, has there been any change in stuttering symptoms? Check those that are appropriate:

Increase in number of repetitions per word ___
Change in amount of force used in speaking ___ (Increased ___ Decreased ___)
Increase in amount of stuttering ___
Increase in length of blocks or prolongations ___
Periods of no stuttering ___ Longer periods of stuttering ___
Lowered voice ___
Increase in pitch while talking ___
Slower speaking rate ___
Change in location of force when stuttering ___
Looking away from the listener ___

Other (please describe) _____

Were there any periods of weeks or months when the stuttering disappeared? _____

_____

Are there any situations that are particularly difficult for your child? If so, please describe. _____

_____

List any situations that never cause difficulty for your child. _____

_____

Indicate "yes" or "no" regarding whether or not your child stutters in the following situations:

_____ Talking to young children
_____ Answering direct questions
_____ Using new/unfamiliar words
_____ Reading out loud
_____ Asking questions
_____ Speaking when tired
_____ Talking to family members
_____ Saying his/her name
_____ Talking to adults/teachers
_____ Using the telephone
_____ Reciting memorized material
_____ Talking to strangers
_____ Speaking when excited
_____ Talking to friends

Does your child know anyone else who stutters? _____ If so, describe relationship _____

Do you feel that stuttering interferes with your child's daily life? _____ Social relationships? _____

Success in school? _____

MEDICAL, DEVELOPMENTAL AND FAMILY HISTORY

Describe mother's health during pregnancy and birth history (i.e., complications) _____

_____

Describe any development problems during your child's infancy or early childhood (i.e., late walking, feeding problems, allergies, late talking) _____

_____

Do you think your child's speech and language development was unusually rapid or delayed? If so, please describe. _____

_____

List any significant illnesses, injuries, or surgical procedures:

Problem	Date	Fever or other complications	Treatment	Physician

List any chronic illnesses, allergies or physical conditions. _____

_____

Vision normal? _____ Hearing normal? _____

Do other members of the family have speech, language, or reading problems? If so, please describe.

_____

_____

Are any family members left-handed, or do they use both right and left hands equally well? _____

_____

Do any family members talk very rapidly? If so, who? _____

SCHOOL AND SOCIAL HISTORY

Favorite subjects or activities in school _____

Difficult subjects in school _____

Hobbies _____ Sports _____

Describe your child's temperament _____

_____

FAMILY CONCERNS (Please use the reverse side if additional space is needed.)

What specific questions do you have about your child that you would like us to try to answer?

_____

_____

_____

_____

What goals would you like to see accomplished as a result of this evaluation?

_____

_____

_____

_____

Are there any concerns that you child has expressed regarding his/her speech or this evaluation?

_____

_____

_____

Are you aware of any other information that you believe we need to know prior to the evaluation?

_____

_____

_____

_____