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 (caaaaaaat)
   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 ___  (Increased ___  Decreased ___)
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  _____ Saying his/her name
_____ Answering direct questions  _____ Talking to adults/teachers
_____ Using new/unfamiliar words  _____ Using the telephone
_____ Reading out loud  _____ Reciting memorized material
_____ Asking questions  _____ Talking to strangers
_____ Speaking when tired  _____ Speaking when excited
_____ Talking to family members  _____ 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:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Date</th>
<th>Fever or other complications</th>
<th>Treatment</th>
<th>Physician</th>
</tr>
</thead>
</table>

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?

________________________________________

________________________________________

________________________________________

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