You have requested a speech/language evaluation or therapy. Attach you will find case history and payment information forms. 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 at a cost of $175.00 and speech language augmentative communication evaluation at a cost of $350.00. Evaluations are needed if there is not a 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. The fees are set at a rate significantly below the community rates. Listed below are the fees based on individual therapy scheduled for 2 hrs/week or for the DLG. This is on a tuition basis, not per session.

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 9:15-11:15.

<table>
<thead>
<tr>
<th>Session Fees</th>
<th>Spring- January through May</th>
<th>$720.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Summer- June through July</td>
<td>$420.00</td>
</tr>
<tr>
<td></td>
<td>Fall- September through December</td>
<td>$720.00</td>
</tr>
</tbody>
</table>

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.
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?  
________________________________________________________________________  

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. __________________________________  
________________________________________________________________________  

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Fever</th>
<th>Complications</th>
<th>Treatment</th>
<th>Physician’s Name</th>
</tr>
</thead>
</table>

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: __________________________
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.
Payment Information

PLEASE PRINT
Clients Name: ___________________ DOB: ________________ SS#______________________

Billing Information: The “Responsible Party” is the person who will receive the monthly bill and make the payments (Parent/Legal Guardian/Other).
Responsible Party’s Name: ______________________________ SS#______________________

Street Address: _________________________________________________________________

City: _________________________ State: _____________________ Zip Code: _____________

Phone: Day (___)___-______ Evening (___)____-______ Cell (___) ___-______

Relationship with Client: Parent____ Legal Guardian ____ Other (Specify)_________________

Payment Option: ___ Single payment ___ Monthly payment ___Weekly payment

___ Provide me with an itemized bill at the end of each month.
___ Provide me with an itemized bill at the end of therapy term.

The Eardley Family Clinic is not an authorized Medicaid or Medicare Provider and does not do any third party billing. Your may request an itemized bill to submit to insurance provider.

I would like the appropriate service (evaluation or therapy), but please do not bill Medicare. Initial_____

I understand that the services I am being provided by the Eardley Family Clinic for Speech, Language and Hearing most likely would not be covered by Medicare. I am aware that the clinic is not a Medicare provider and therefore any fees incurred may not be submitted to Medicare for reimbursement. If at any time, the services provided would be Medicare covered services, the clinic would be required to refer to a Medicare facility. Initial_____

All information will remain confidential and is for the clinic administrative staff use only