Speech Therapy – Fluency Supplement

Patient Name: ______________________

DOB: ______________________

*Depending on your child's age, some questions may not be applicable.

Concerns

1. Describe your child's speech.

2. When did your child first start stuttering?

3. Were there any signs or developmental changes observed in your child's life when he/she first began stuttering? If so, please describe.

4. Has your child's stuttering changed since it first begun? If so, describe.

5. Did you take any steps to address your concerns once they arose (i.e., past assessments, therapy)?

6. Please make an estimate as to **how often** your child currently stutters (percentage).

7. Is there a history of a speech and/or language disorder (stuttering or speech sound problems) on either side of the family?

8. What you have done or others done to help your child stutter less? Please explain. Did someone tell you about these strategies?
____
____

9. Please list anything that you have tried to reduce your child's stuttering. What were the results?
____
____

10. Does your child demonstrate any of the following:

-Awareness of stuttering _____
-Physical tension during stuttering _____
-Frustration when speaking _____
-Says that he/she "can't talk" _____
-Eye blinking, looking away, facial grimaces, etc _____

11. Has your child ever been teased for stuttering? Yes No

12. Has your child ever discussed/talked about his/her speaking difficulties with you? Yes No

13. Rate how often your child is able to speak fluently in the following situations (circle one in each column):

-At home	Always	Almost always	Sometimes	Rarely	Never
-At school	Always	Almost always	Sometimes	Rarely	Never
-In new situations	Always	Almost always	Sometimes	Rarely	Never

14. How does your child's stuttering affect the following:
-Academic performance ____
____
-Participation in school activities____
____
-Interaction with other peers ____
____
-Interaction with other family members_______________________________________
____
-Willingness to talk____
____
-Self-esteem or attitude toward self____
____

15. How often do the following behaviors occur? (Circle one in each column).

-Inattentiveness	Always	Almost always	Sometimes	Rarely	Never
-Hyperactivity	Always	Almost always	Sometimes	Rarely	Never
-Nervousness	Always	Almost always	Sometimes	Rarely	Never
-Sensitivity	Always	Almost always	Sometimes	Rarely	Never

-Perfectionism	Always	Almost always	Sometimes	Rarely	Never
-Excitability	Always	Almost always	Sometimes	Rarely	Never
-Frustration	Always	Almost always	Sometimes	Rarely	Never
-Strong fears	Always	Almost always	Sometimes	Rarely	Never
-Competitiveness	Always	Almost always	Sometimes	Rarely	Never
-Excessive neatness	Always	Almost always	Sometimes	Rarely	Never
-Excessive shyness	Always	Almost always	Sometimes	Rarely	Never
-Lack of confidence	Always	Almost always	Sometimes	Rarely	Never

Learning Style:

1. What are specific communication situations that are most challenging for your child?
   ____
   ____
2. How does your child learn best? (Reading, Listening, Demonstration, Pictures)
   ____
   ____
3. How do you learn best? (Reading, Listening, Demonstration, Pictures)
   ____
   ____
4. What are your child's favorite toys/activities that will be helpful for them to feel comfortable during the evaluation?
   ____
   ____
5. Is there anything else you would like to share with us?
   ____
   ____

Thank you for taking the time to complete this form.
Your contribution to this evaluation process is greatly appreciated and valued.
We look forward to meeting you. ☺