Clear Speech & Language

Date: _____/_____/_____

FLUENCY HISTORY FORM

General Patient Information

Patient Name: _____ Date of Birth: _____

Pediatrician: _____ Date Last Seen by Pediatrician: _____

Other specialists who have worked with this child: _____

Primary concerns or reasons for seeking services: _____

_____

Health & Developmental History

Length of pregnancy: _____ Child's birth weight: _____

Any illnesses, injuries, or complications during the pregnancy/delivery? □ yes □ no

Were there any concerns following the child's birth? □ yes □ no

Has this child had any serious illnesses or injuries? □ yes □ no

Describe: _____

Is the child taking any medications? □ yes □ no

Details: _____

Has hearing been tested? □ yes □ no Results: _____

Has vision been tested? □ yes □ no Results: _____

Has this child had repeat ear infections? □ yes □ no

If P.E. tubes were ever placed, by whom and when: _____

Is there a family history of speech, language, or learning problems? □ yes □ no

If yes, explain: _____

Does this child have a history of problems with chewing, feeding, swallowing, or drooling? □ yes □ no

Has this child been given any previous diagnosis? □ yes □ no

Developmental Milestones

Please note at what age this child first:

Sat alone _____

Crawled _____

Walked _____

Was toilet trained _____

Babbled _____

Spoke first word _____

Put two words together _____

Health or Developmental Concerns

□ Behavior

□ Attention/concentration

□ Social interactions

□ Eye contact

□ Self-help skills

□ Play skills

□ School achievement

□ Interest in a variety of activities

□ Gross motor skills (walking, sitting, jumping)

□ Fine motor skills (drawing, writing, object manipulation)

□ Balance/coordination

□ Physical health

□ Hearing

□ Vision

□ Diet/eating

□ Other: _____

Additional information: _____

Educational/Academic

Does your child currently attend school? □ yes □ no

Name of school: _____

At what age did your child first start attending school? _____

Have there been any concerns as noted by teachers? □ yes □ no

If yes, please explain: _____

_____

Speech and Language History

What prompted your concerns regarding this child's speech and/or language development?

_____

Has the child received previous speech and language therapy? □ yes □ no

What languages are spoken in the home? _____

If your child is learning more than one language, does the child use/understand both? □ yes □ no

Please describe: _____

Fluency/Stuttering

When did the dysfluency/stuttering first start or become noticeable? _____

Was the onset sudden or gradual? _____

Please explain: _____

Is there a family history of stuttering? □ yes □ no If yes, who? _____

Does the child demonstrate any frustration when in a moment of stuttering? □ yes □ no

Situations when your child regularly seems to experience increased stuttering (please check all that apply):

□ when tired
□ when excited
□ when speaking with family
□ when speaking with peers
□ when speaking with siblings
□ when speaking with extended family
□ at school
□ when telling stories
□ when talking on the phone
□ other: _____
_____

Behaviors observed during moments of stuttering (please check all that apply):

□ repeats parts of words (ca-ca-cat)
□ repeats whole words (my-my-my-game)
□ repeats phrases
□ prolongs certain sounds
□ unusual changes in loudness or pitch
□ demonstrates tension in his/her face or body
□ excessive or unusual hand or body movements
□ blocks (often looks like words get "stuck")
□ avoids eye contact
□ other: _____

On a scale of **1 (no stuttering) to 5 (most severe stuttering)**, rate your child's stuttering behavior on a typical day:	1	2	3	4	5

On a scale of **1 (never) to 5 (always)**:

My child's stuttering worries me:	1	2	3	4	5
My child's stuttering interferes with his/her ability to communicate:	1	2	3	4	5
My child avoids speaking situations because of stuttering:	1	2	3	4	5
Other people have noticed/commented on my child's stuttering:	1	2	3	4	5

Is there anything else you would like me to know?