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# Fluency Case History Form

Date:_____

Child's Name:_____ Date of Birth:_____ □ Male □ Female

Home Address:_____

Home Phone #: _____

Form Completed by: □ Mother □ Father □ Guardian □ Caregiver □ Other: _____

**Family Information:**

Parent/Guardian: _____ Age: _____ Occupation: _____

Address: _____ Alt. Phone #: (work) _____ (cell)_____

Parent/Guardian: _____ Age: _____ Occupation: _____

Address: _____ Alt. Phone #: (work) _____ (cell)_____

| Name(s) of Others Living with the Child: | Relationship to Child: | Age: | Sex: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

What languages are spoken in the home? _____

What is the primary language used with this child? _____

Was this child adopted? □ No □ Yes If Yes, at what age? _____ From where? _____

Is there any family history of stuttering?_____ If yes, who?_____

**Child's Medical History:**

Name of child's physician: _____ Medical office: _____

Describe the mother's health during pregnancy: □ Good □ Fair □ Poor

Were there any unusual conditions or problems during the pregnancy or birth? □ No □ Yes If yes, please describe:

_____

_____

Were there any drugs or alcohol consumed during the pregnancy? □ No □ Yes If yes, what and how often?

_____

Was the pregnancy full term? □Yes □No If no, how early or late? _____

General condition: _____ Birth weight: _____

Does your child have any medically diagnosed illness or conditions? □Yes □ No If yes, please explain: _____

_____

Is your child taking any medications? □Yes □No If yes, please list: _____

Has your child experienced any of the following?

□ Frequent Colds □ Seizures □ Snoring □ Mouth Breathing

□ Sleeping Problems □ Frequent Ear Infections □ Other: _____

Has your child had any surgeries, accidents or hospitalizations? □ No □ Yes If yes, please explain: _____

_____

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.)?
□ No □ Yes If yes, please explain: _____

Is there anything else we should know about your child's medical history? □ Yes □ No If yes, please explain:

_____

_____

Has your child had any of the following evaluations or assessments? Please indicate:

□ Hearing □ Speech and Language □ Psychological □ Physical Therapy

□ Neurological □ Occupational Therapy □ Developmental □ Vision

What were the results? _____

_____

_____

Has your child received any of the following services? □ Speech/Language □ OT □ PT □ Nursing

**Please be sure to provide copies of any evaluations, treatment plans, or IEPs, etc.*

**Onset of Stuttering**

At what age was the stuttering first noticed? _____

Please describe how the stuttering sounded when it first occurred (check all that apply).

__ Stuttering at the beginning of words
__ Stuttering in the middle of words
__ Repeating whole words (you...you...you)
__ Repeating parts of words (ta...ta...table)
__ Repeating phrases (That is...that is mine)
__ Blocking or pushing sounds or words out with force
__ Prolonging or extending a sound in a word (mmmmmmmmine)
__ Giving up the attempt to talk
__ Unexpected and sudden pitch changes within a word
__ Avoiding talking
__ Substituting one word for another
__ Commenting that "talking is hard", that a word "gets stuck" or some other statement:_____

Do you know of any unusual events that occurred around the time the stuttering began?

_____

_____

When the stuttering was first noticed, what was the child's reaction? _____

_____

What was your reaction? _____

Is your child aware of his stuttering? _____

**Current Description of Child's Fluency**

What types of dysfluencies do you see and how often (please check)?

| Type | Seldom/Not Observed | Sometimes | Often |
|---|---|---|---|
| Hesitations – Pauses as if thinking about what to say before or during speaking. | | | |
| Interjections – Inserting extra words when speaking (e.g. Um, like, you know). | | | |
| Revisions of phrases or sentences/Changes what is said (e.g. I want to, I'd like to go somewhere, can I go with you?). | | | |
| Phrase repetitions (e.g. Mom can I, can I, get some candy?) | | | |
| Whole word repetitions (e.g. Can, Can, Can I get some candy?) | | | |
| Part-word repetitions (e.g. Ca-ca-can I get some candy?) | | | |
| Sound repetitions (e.g. C-c-can I get some candy?) | | | |
| Prolongations – stretching or holding onto a sound (e.g. MMMMMom I want that.) | | | |
| Blocks – noticeable tension/no speech comes out. | | | |
| Unusual face/body movements (e.g. blinking eyes, head/jaw jerking, stomping foot) during moments of stuttering. | | | |
| Unusual breathing patterns during speech | | | |

How has the stuttering changed over time (either in terms of quantity or quality)? (describe and check/circle all that apply)

_____

_____

__ Overall increase / decrease in the amount of stuttering
__ Increase / decrease in number of repetitions
__ More / less force used to get out a word
__ Longer / shorter duration of prolongations
__ Slower / faster speech rate
__ Changes in loudness during stuttering
__ Changes in pitch during stuttering
__ Changes in eye contact during stuttering
__ Changes in body language / body movement during stuttering
__ Other _____

How do family members react to the stuttering? _____

_____

How do peers react to the stuttering? _____

_____

In what situations is the most stuttering noted? _____

_____

In what situations is the least stuttering noted? _____

_____

Are there periods when there is significantly more / less stuttering? (weeks / months)? _____

Please describe and indicate how long these periods last:_____

_____

Which of the following factors do you feel may contribute to an <u>increase</u> in the stuttering (check/circle all that apply)?

| Internal Factors (within the child) | External Factors (environment) |
|---|---|
| Fatigue | Being interrupted |
| Illness | Getting listener attention |
| Excitement | Being rushed/time pressure |
| Fears | Being put on the spot to speak |
| Competition | Talking to peers |
| Increased rate of speech | Talking to parents |
| Asking questions | Talking to siblings |
| Searching for words | Talking in large groups |
| Trying to be understood | Conflict situations |
| Formulating stories | Surprises/unexpected events |
| Lack of confidence | Talking on the phone |
| Low frustration tolerance | Inattentive/busy listeners |
| Trying to get attention | Talking to adults/teachers |
| Being unsure about topic | |

**Behavior History:**

| | Often | Sometimes | Never |
|---|---|---|---|
| Does your child seem unusually quiet? | | | |
| Does your child seem to be restless or fidgety? | | | |
| Does your child get upset easily? | | | |
| Does your child rock his/her body? | | | |
| Does your child enjoy "messy" play? | | | |
| Does your child bump or push others? | | | |
| Does your child pinch, bite or hurt oneself? | | | |
| Does your child have a difficult time with change? | | | |
| Is your child easily distracted? | | | |
| Does your child understand personal safety? | | | |
| Does your child enjoy the company of other children? | | | |
| Does your child enjoy reading or having books read to him/her? | | | |

Describe your child: (Check all that apply)

□ Friendly □ Shy □ Cooperative □ Independent □ Stubborn □ Difficult to handle □ Other _____

Do you have any concerns about your child's behavior? If so, please describe:_____

_____

**Educational History:**

Is your child currently attending daycare/school: □ Yes □ No Where: _____

Number of hours per week: _____ How is your child doing in the program? _____

Does your child receive any special services at school? If yes, please describe: _____

_____

How does your child interact with others (e.g., friendly, shy, cooperative, etc.)? _____

Do you have any concerns about your child's behaviors at school? If so, please describe: _____

_____

**Additional Information**

Has anyone (to your knowledge) teased or drawn attention to your child's stuttering? _____ If so, please describe:

_____

Have you received advice about this problem from anyone? _____

If so, please describe: _____

_____

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

Success in school? _____

If so, please describe:_____

_____

What do you see as your child's strengths? _____

_____

What does your child enjoy playing with or enjoy doing?_____

_____

What motivates your child?_____

_____

Are there any other comments/concerns?

_____

_____

_____

_____

_____

_____