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Intake Form for Preschool and School-Age Children

Child

Name: _____ Check one: Male ___ Female ___
 Date of Birth: _____ Age: _____
 Home Address: _____ Home Phone: _____
 City, State Zip _____ Referred by: _____

Parent(s) / Guardian(s)

Mother: _____ Occupation: _____ Day Phone: _____
 Address (if different from above): _____
 Father: _____ Occupation: _____ Day Phone: _____
 Address (if different from above): _____

Other People in the Household:

Name _____	Age _____	Relationship _____
Name _____	Age _____	Relationship _____
Name _____	Age _____	Relationship _____

History of Speech/Language Problems

- Describe your child's speaking difficulty in your own words: _____

- At what age was this problem first noticed? _____
- Who first noticed the problem? _____
- How has the problem changed since that time? _____

- Do you have difficulty understanding your child? _____
- Do other people have difficulty understanding your child? _____

7. Has your child previously been assessed for speech/language concerns? Yes No

If so, describe: _____

8. Has your child received any prior speech/language therapy? Yes No

If so, where? _____ By whom? _____

For how long? _____ Focus of Treatment: _____

Results of Treatment: _____

9. Have any other family members had speech/language problems? Yes No

Indicate the person's relationship to the child and the nature of the problem. _____

Medical History and Current Health Status

1. Was there anything remarkable about the mother's health during pregnancy or delivery? _____

2. Was there anything remarkable about the child's condition at birth? _____

3. Does the child have developmental concerns other than the speech/language problem? Yes No

Describe _____

4. At approximately what age did your child begin to:

walk _____ use words _____ combine words _____

5. Has your child experienced ear infections? Yes No

Approximately how often (circle one)? Rarely Occasionally Frequently

Has your child's hearing ever been tested? Yes No Results _____

Do you feel your child hears normally? Yes No Explain _____

6. Indicate if your child has experienced the following medical problems.

Chicken Pox _____ Tonsillitis _____ Vision Problems _____

Pneumonia _____ Headaches _____ High Fever _____

Seizures _____ Allergies _____ Asthma _____

7. Describe illnesses, accidents, injuries, hospitalizations (include age/treatment): _____

8. How often do the following behaviors occur? (O = Often, S = Sometimes, N = Never)

- | | | | | | | | |
|--------------------|---|---|---|-----------------------|---|---|---|
| a. Inattentiveness | O | S | N | g. Frustration | O | S | N |
| b. Hyperactivity | O | S | N | h. Strong fears | O | S | N |
| c. Nervousness | O | S | N | i. Excessive neatness | O | S | N |
| d. Sensitivity | O | S | N | j. Excessive shyness | O | S | N |
| e. Perfectionism | O | S | N | k. Lack of confidence | O | S | N |
| f. Excitability | O | S | N | l. Competitiveness | O | S | N |

9. What is your child's current health? good _____ fair _____ poor _____

Is your child currently taking any medication? Yes No If so, what? _____

Does your child have any other medical diagnoses or concerns? _____

Speech Fluency and Stuttering

1. When did your child first start stuttering? (Be as specific as possible.) _____

2. What did the stuttering sound like when it first began? _____

3. Describe how your child's speech sounds now. _____

4. What seems to help your child when he or she is stuttering? _____

5. Has your child ever demonstrated any:

awareness of stuttering _____ physical tension during stuttering _____

frustration about speaking _____ complaints that s/he "can't talk" _____

Describe _____

6. Has your child ever been teased about stuttering? Yes No

Describe _____

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

Describe _____

8. Is there any history of stuttering in the family? _____

Do any of the child's parents, brothers, or sisters stutter? _____

Anyone on child's mother's side? _____ Anyone on child's father's side? _____

Describe the relative(s)' stuttering. _____

9. Have you or your child ever known another person who stutters? Yes No

Who? _____

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

<u>At Home</u>	<u>At School</u>	<u>In New Situations</u>
Always	Always	Always
Almost Always	Almost Always	Almost Always
Sometimes	Sometimes	Sometimes
Rarely	Rarely	Rarely
Never	Never	Never

11. Rate how often your child is able to speak freely, regardless of fluency (circle one in each column):

<u>At Home</u>	<u>At School</u>	<u>In New Situations</u>
Always	Always	Always
Almost Always	Almost Always	Almost Always
Sometimes	Sometimes	Sometimes
Rarely	Rarely	Rarely
Never	Never	Never

12. How does the child's stuttering affect his or her:

Academic performance? _____

Participation in school activities? _____

Interaction with other children? _____

Interaction with family members? _____

Willingness to talk and communicate? _____

Self-esteem or attitude toward self? _____

13. What else do you think we should know about your child (e.g., hobbies, interests, social skills)?

14. If you would like to receive the Stuttering Center's e-Newsletter, please provide your email address:
