SOUTHERN ILLINOIS UNIVERSITY
EDWARDSVILLE

SPEECH-HEARING-LANGUAGE CENTER
CLIENT INFORMATION FORM – FLUENCY CHILD

Name: _____ Sex: _____ Date of Birth: _____ Age: _____

Race: (circle one) Caucasian African-American Hispanic Asian Native American Other

Address: _____
(street) (city) (state) (zip)

Home Phone: _____

Father: _____ Age: _____ Occupation: _____

Education: (circle one) Less than high school High School GED Some College B.A./B.S. Post-Graduate

Address: _____
(street) (city) (state) (zip)

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Mother: _____ Age: _____ Occupation: _____

Education: (circle one) Less than high school High School GED Some College B.A./B.S. Post-Graduate

Address: _____
(street) (city) (state) (zip)

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Referred by: _____ Pediatrician: _____ Phone: _____

School: _____ Phone: _____ Grade: _____

Person filling out this questionnaire: _____
(name) (relationship) (phone #)

Other children in home: (name, age) _____

Please answer the following questions:

SPEECH/LANGUAGE CONCERNS:

1. What language is spoken in the home? What is the child's primary language?

2. Describe as completely as possible the child's speech problem.

3. When was the problem first noticed? By whom?

4. What do you think may have caused the problem? Has the problem changed since first noticed?

5. Is the child aware of the problem? If yes, how does he/she feel about it?

6. Have any other speech-language specialists seen the child? Who and when? What were their conclusions or suggestions?

7. Is the child currently receiving therapy? If yes, where and how often?

HEARING CONERNS:

1. Have you ever questioned your child's ability to hear normally? If yes, explain why.

2. Has your child ever had ear infections? If yes, right or left ear, and please describe.

3. Has your child ever been exposed to loud noise or explosion? If yes, please explain.

4. Does your child ever complain of fullness in the ear or describe a noise in his ear? If yes, please explain.

5. Is his/her hearing the same from day to day? If no, under what conditions does it very?

6. What type of sound does the child respond to? Circle any that apply.

a.	Loud airplane	Yes	No
b.	Doorbell or phone	Yes	No
c.	Speech over the phone	Yes	No
d.	Speech when facing speaker	Yes	No
e.	Speech over radio at normal volume	Yes	No

f.	Speech on TV with normal volume	Yes	No
g.	Speech with back to speaker	Yes	No
h.	Speech from another room	Yes	No
i.	Whispered speech	Yes	No
j.	Very faint sounds	Yes	No
k.	Soft music	Yes	No

7. Does the child become confused with direction of sound? Yes No

8. Does your child seem to hear better in noisy or quiet situations?

9. Is your child annoyed by noisy environment or loud sounds? Yes No

10. Does your child favor one ear? If yes, which ear?

11. Does the child watch the speaker's face? Yes No

12. Does the child respond to vibration? Yes No

13. Does the child wear a hearing aid? If yes, which ear? Type: _____

MEDICAL HISTORY

1. Mother's general health during pregnancy (illnesses, accidents, medications, etc)?

2. Length of pregnancy _____ Length of labor _____
   Circle one: Head first
   Breech/feet first
   Scheduled Caesarian If Caesarian, why? _____
   Emergency Caesarian
3. Were there any unusual conditions that may have affected the pregnancy, birth or period directly following birth?

4. Please circle any medical conditions that pertain to the child:

Allergies	Asthma	Chicken Pox	Colds	Croup	Convulsions
Dizziness	Draining Ear	Ear Infections	Encephalitis	Headaches	German Measles
Head Injury	High Fever	Influenza	Mastoiditis	Measles	Meningitis
Mumps	Pneumonia	Seizures	Sinusitis	Tinnitus	Tonsillitis

   Other (s): _____

5. Has the child had any surgeries? If yes, what type and when (e.g. tonsillectomy, adenoidetomy, etc.)

6. Describe any major accidents or hospitalizations?

7. Has the child ever been hit on the ear? If yes, please explain.

8. Is the child taking any medications? If yes, please identify and give dosage and times.

9. Have there been any negative reactions to medications? If yes, please identify.

DEVELOPMENTAL HISTORY

1. Provide the approximate age at which the child began to do the following activities:
   Crawl _____ Sit _____ Stand _____ Walk _____
   Feed Self _____ Dress Self _____ Use Toilet _____
   Use single words (e.g. *no, mommy, doggie,* etc.) _____
   Combine words (e.g. *me go, daddy shoe,* etc.) _____
   Name simple objects (e.g. *dog, car, tree,* etc.) _____
   Use simple questions (e.g. *Where's doggie?* etc.) _____

2. Does the child have difficulty walking, running, or participating in other activities, which require small or large muscle coordination? If yes, please describe.

3. Are there or have there ever been any feeding problems (e.g. problems with sucking, swallowing, drooling, chewing, etc.)? If yes, please describe.

4. Did speech learning ever seem to stop for a period? If yes, please describe.

5. Has there been a change in the child's speech or hearing in the last six months? If yes, please describe.

EDUCATIONAL HISTORY

1. How is the child doing academically? (or preacademically?)

2. Does the child receive special services? If yes, please describe.

3. How does the child interact with others (e.g. shy, aggressive, uncooperative, etc.)?

4. If enrolled for special education services, has the Individualized Education Plan (IEP) been developed? If yes, describe the most important goals?

5. Provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

Assessment of Stuttering Behaviors
Parental Diagnostic Questionnaire
by Dennis C. Tanner, Ph.D.

Do you believe this child is a stutterer?

____ Yes ____ No

If *yes*, please describe the stuttering behaviors that have been observed:

How long has your child been displaying the behaviors of stuttering?

In the past six months, has there been any change in the severity of the stuttering problem?

____ Yes ____ No

If *yes*, what changes have been noticed?

____ Problem has become more severe.

____ Problem has become less severe.

____Other (specify):_____

Are there family members or other relatives with stuttering problems?

____ Yes ____ No

If *yes*, list names, relationship to child, and frequency the child has contact with these individuals.

Name	**Relationship**	**Frequency of Contact**

Do you believe your child is aware that there is something wrong with his/her speech production?

____ Yes ____ No

If *yes*, how does the child show this awareness?

Some children with stuttering problems exhibit **abnormal visible features** such as protruding the tongue, making facial grimaces, throwing the head back, eye squints, hand slaps, leg movements, etc. The abnormal visible features usually occur during the stuttering moments and are the result of attempts to force out speech.

When your child talks, are any abnormal visible features displayed?

____ Yes ____ No

If you answered *yes* to the above question, list the abnormal visible features in order of their prominence (the extent to which they are apparent and obvious). For example, if the child's most apparent abnormal visible feature is the squinting of eyes during the stuttering moment, list "eye squints" first, the next more obvious feature second, and so forth.

Visible Features

(most obvious)

1. _____
2. _____
3. _____
4. _____
5. _____

(least obvious)

Abnormal visible feature which occurs most frequently:

_____

Abnormal visible feature which occurs least frequently:

_____

Comments:

Section 1- Speech Behaviors

Instructions: Circle the number which most accurately represents your child's speech behavior.

	Never		Sometimes		Always
1. My child struggles to get the words out.	1	2	3	4	5
2. When my child repeats syllables, he/she appears to be struggling.	1	2	3	4	5
3. When my child starts to talk, his/her lips appear to tremble.	1	2	3	4	5
4. There is a tremor (trembling) in my child's jaw when he/she starts to talk.	1	2	3	4	5
5. When my child repeats syllables, he/she repeats more than two syllables per word.	1	2	3	4	5
6. When my child repeats syllables, the time interval between those syllables is not regular.	1	2	3	4	5
7. My child repeats, prolongs, or hesitates on the schwa vowel "uh."	1	2	3	4	5
8. My child makes word substitutions when he/she talks.	1	2	3	4	5

	1 Never	2	3 Sometimes	4	5 Always
9. When my child talks, he/she appears to avoid eye contact with others.					
10. My child's voice changes pitch inappropriately when he/she is talking.	1	2	3	4	5
11. My child complains of a tense or strained feeling in his/her throat.	1	2	3	4	5
12. When my child repeats syllables, his/her airflow is interrupted with gasping.	1	2	3	4	5
13. When my child talks, the last part of the word ends suddenly.	1	2	3	4	5
14. There are gaps – silent pauses – which occur within the word my child speaks.	1	2	3	4	5
15. There are long pauses between the words in my child's speech.	1	2	3	4	5
16. There are unusually long silences or gaps before my child begins talking.	1	2	3	4	5
17. My child appears to be afraid to talk.	1	2	3	4	5
18. My child becomes frustrated because he/she cannot talk properly.	1	2	3	4	5
19. My child appears to be afraid to talk to people he/she does know because of repetitions, prolongations, or hesitations.	1	2	3	4	5
20. My child is uneasy and strained when he/she is talking.	1	2	3	4	5

Section 2- Parental Responses to Stuttering

Instructions: Read each statement and circle the most appropriate response.

	Never		Sometimes		Always
1. I tell my child to speak more slowly.	1	2	3	4	5
2. I remind my child not to stutter.	1	2	3	4	5
3. I require my child to repeat words.	1	2	3	4	5
4. I require my child to stop and start over when he/she is having problems with a word.	1	2	3	4	5
5. When my child makes a speech error, I make fun of him/her.	1	2	3	4	5
6. I become impatient when my child has problems speaking.	1	2	3	4	5
7. I give my child more attention when he/she does not speak properly.	1	2	3	4	5

	Never		Sometimes		Always
8. I allow my child to know I am annoyed when he/she does not speak properly.	1	2	3	4	5
9. I speak for my child when he/she cannot seem to get the words out.	1	2	3	4	5
10. I remind my child to think before talking.	1	2	3	4	5

Comments: