



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 _____

Babbled _____

Crawled _____

Spoke first word _____

Walked _____

Put two words together _____

Was toilet trained _____

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

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

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

