Speech & Voice Experience

Stuttering Case History
Adolescent/Adult

Please fill out this form as completely as possible. If you need more space, attach another page.

Thank you for taking the time to fill out these forms. Complete case history forms are essential to receiving a thoughtful and well-designed evaluation. By sending these completed forms to our office at least TWO DAYS PRIOR to your appointment, we are able to best determine how to maximize our time with you. We look forward to meeting you.

I. Identifying and Family Information

Date: ______________________________

Patient Name:____ Birthdate:__________________ Age:_____

Address:____

Home Phone:____ Cell Phone:________________________

Email address:____

Preferred Method of Contact: ❑ Phone Call ❑ Text ❑ Email Other:________________________

Is there a language other than English spoken in the home? ❑ Yes ❑ No

If yes, which language?____

If patient is an adolescent:

Caregiver's Name(s):____

Relation to child:____

Child's school:____ Grade:______________________

II. Physician Information

Referring Physician:____

Physician's Phone Number:____

Physician's Address:____

III. History of the Problem

1. Approximate age at which stuttering was first noticed: ____
2. Who first noticed or mentioned the stuttering? ____
3. In what situation was the stuttering first noticed? ____

   ____
4. Describe any situations, conditions, or injuries that might be associated with the onset of stuttering:

   ____

   ____
5. Describe your stuttering when it first started. (Where was the tension? Blocks? Prolongations?)

   ____

   ____

Patient Name:________________________________ Date of Birth: ___________________

6. Was your stuttering always the same or did it occur in several different ways? ___________________
____

7. If it occurred in different ways, please describe how they were different from one another.
____
____

8. Was the stuttering easy or was there force at the time when stuttering was first noticed?
____

9. Were the words that were stuttered at the beginning of sentences or were they scattered throughout the sentence being spoken? ____
____

10. When stuttering first began, was there any avoidance of speaking as a result? Please give examples, if any: ____
____

11. Please list any situations where you notice little or no stuttering: _____________________________
____

12. Indicate Yes or No if you stutter in the following situations:

Talking to young children:	❑ Yes ❑ No	Using new/unfamiliar words:	❑ Yes ❑ No
Talking to family members:	❑ Yes ❑ No	Reading out loud:	❑ Yes ❑ No
Talking to adults/superiors:	❑ Yes ❑ No	Speaking when tired:	❑ Yes ❑ No
Talking to friends:	❑ Yes ❑ No	Speaking when excited:	❑ Yes ❑ No
Talking to strangers:	❑ Yes ❑ No	Saying your name:	❑ Yes ❑ No
Asking questions:	❑ Yes ❑ No	Using the telephone:	❑ Yes ❑ No
Answering direct questions:	❑ Yes ❑ No	Reciting memorized material:	❑ Yes ❑ No

13. Is there anything that makes the stuttering better? ❑ Yes ❑ No If yes, please explain: ________
____
____

14. Is there anything that makes the stuttering worse? ❑ Yes ❑ No If yes, please explain: ________
____
____

15. What attempts have been made to treat the stuttering problem (either formally or informally)? ____
____
____
____

Patient Name:________________________________ Date of Birth: ___________________

IV. Development of Stuttering

1. Since the onset of stuttering, has there been any change in stuttering symptoms? ❑ Yes ❑ No
   If yes, please check those applicable:
   - ❑ Increase in number of repetitions per word
   - ❑ Increase in amount of stuttering
   - ❑ Increase in length of blocks or prolongations
   - ❑ Increase in pitch while talking
   - ❑ Change in location of force when stuttering
   - ❑ Change in amount of force used in speaking
     ❑ Increased ❑ Decreased
   - ❑ Periods of no stuttering
   - ❑ Longer periods of stuttering
   - ❑ Slower speaking rate
   - ❑ Looking away from the listener
   - ❑ Lowered voice
   - ❑ Other: ____

2. Were there any periods of extended time when the stuttering disappeared? Increased?
   Please describe: ____
   ____

3. Are there any situations that are particularly difficult? Particularly easy? Please describe: __________
   ____
   ____

4. How would you describe your moments of stuttering? Please check all that apply:
   - ❑ Complete audible blocks
   - ❑ Complete inaudible blocks
   - ❑ Repetitions of whole words
   - ❑ Repetitions of the first letter in words
   - ❑ Repetitions of the first syllable in words
   - ❑ Prolongations of consonants
   - ❑ Prolongations of vowels

5. Do you feel that stuttering interferes with your:
   - ❑ daily life
   - ❑ career
   - ❑ social relationships
   - ❑ success on the job
   - ❑ success in school

V. Medical, Developmental, and Family History

1. List any significant illnesses, injuries, or surgical procedures:

Problem	Date	Fever or complications	Treatment	Physician

2. List any chronic illnesses, allergies, or physical conditions: ________________________________
   ____
   ____

Patient Name:______________________________ Date of Birth: __________________

3. Normal vision? ❑ Yes ❑ No Normal hearing? ❑ Yes ❑ No
4. Do other members of the family have speech, fluency, language, or reading problems? If so, please describe: ____

____

5. Are any family members left-handed or do they use both right and left hands equally well (ambidextrous)? ____
6. Do any family members talk very rapidly? ❑ Yes ❑ No If so, who? ______________________

VI. Family Questions, Concerns, and Goals (Please use reverse side if additional space is needed)

1. What specific questions do you have that you would like us to try to answer?

____

____

____

____

2. Do you have any other speech, articulation, language, or social communication concerns? ________

____

____

____

3. What goals would you like to see accomplished as a result of this evaluation? __________________

____

____

____

4. Please share any other information that you believe we need to know prior to the evaluation: _____

____

____

____

____