Stuttering Center of Western Pennsylvania
A joint venture of Children's Hospital of Pittsburgh and the Department of Communication Science and Disorders at the University of Pittsburgh

The Stuttering Center of Western Pennsylvania

J. Scott Yaruss, Ph.D. CCC-SLP
(412) 383-6538, jsyaruss@csd.pitt.edu

Craig Coleman, M.A., CCC-SLP
(412) 666-3825, Craig.Coleman@chp.edu

Referrals: (412) 692-5575 (Children's Hospital, Oakland)
Website: www.stutteringcenter.org

Diagnostic 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

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

   _____

2. At what age was this problem first noticed?_____

3. Who first noticed the problem? _____

4. How has the problem changed since that time? _____

   _____

5. Do you have difficulty understanding your child? _____

6. 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):

At Home	At School	In New Situations
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):

At Home	At School	In New Situations
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. W hat 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:

_____