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Adult and Teen Case History Form

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

Referred by: _____

School and year or Education Level and Occupation:

_____

Marital Status:

_____

First Language(s): _____ Other Language(s):_____

Names and ages of Children (if applicable):

_____

Person completing this form:

_____

1. Please describe the current speech and language concerns you have.

2. Do you have a family history of stuttering or cluttering?

Please list family members who also stutter(ed) or clutter(ed):

Relation (names optional):	Stutter(ed) as an adult? / Only as a child? / Other?

3. At approximately what age did your stuttering or cluttering begin?

4. Was the onset of your stuttering or cluttering sudden or gradual?

5. Were there any stressful life events that occurred around the time your stuttering began? If yes, please explain:

6. Have you received any form of speech therapy for your stuttering or cluttering in the past?

If yes, please indicate details below:

Type of Therapy	Amount of Time in Therapy	Age
Elementary School Speech Therapy		
Middle School Speech Therapy		
High School Speech Therapy		
College Speech Clinic		
Psychotherapy		
Drug Therapy		
Private Speech Therapist		
Intensive Treatment Program If so, which one? _____		

7. What approaches/techniques have you been taught in treatment?

[ ] Acceptance of Stuttering
[ ] Stuttering Modification
[ ] Hypnosis
[ ] Avoidance Reduction Therapy
[ ] Delayed Auditory Feedback
[ ] Breathing
[ ] Slowed Speech
[ ] Nervous System Regulation
[ ] Voluntary Stuttering
[ ] Advertising/Self-Disclosure
[ ] Fluency Shaping
[ ] Desensitization
[ ] Meditation
[ ] Values Work
[ ] Other _____

8. Have you seen any other specialists (physicians, psychologists, neurologists, etc.) in regards to stuttering or cluttering? If yes, indicate the type of specialist, when you were seen, and the specialist's conclusions or suggestions.

9. What do you hope to gain from this evaluation/consultation?

10. List all medications you are taking.

11. List all illnesses, injuries, operations, and hospitalizations:

12. List any special conditions that are applicable to you. For example: cerebral palsy, physical disabilities, learning disabilities, cognitive impairment, asthma, ADHD, psychological/psychiatric conditions, drug/alcohol dependencies, etc.

13. Health (check one): [ ] Excellent [ ] Fair [ ] Poor

Describe health problems:

14. Vision: [ ] Within Normal Limits [ ] Glasses [ ] Contacts

15. Hearing: [ ] Within Normal Limits [ ] Deaf [ ] Hard of hearing

16. Please provide any additional information that might be helpful or anything else you would like for me to know.