Chamonix Olsen Sikora M.S., CCC-SLP, BCS-F
Speech-Language Pathologist, Board Certified Specialist in Fluency
www.hopeforstuttering.com

Child Case History Form

Date: _____

Child's Name: _____ Date of Birth: _____

Address: _____

Parent One:
Name: _____
Phone: _____
Email: _____

Parent Two:
Name: _____
Phone: _____
Email: _____

Referred by: _____

School: _____

Teacher's Name: _____ Grade: _____

Pediatrician (name & address): _____

Person Completing Form: _____ Relationship to Child: _____

Emergency Contact Name and Phone Number: _____

Speech and Language History

(1) Please describe your child's current speech and language skills and any concerns you have.

(2) Is English your child's first language? ____ (Y / N)

Are you bilingual? ____

Is your child bilingual? ____ If yes, does your child stutter more in one language than another? Please explain.

List all languages spoken at home.

(3) What was the approximate age that your child began having difficulty with stuttering?

(4) Was there anything going on in your child's life around the onset of the stuttering (i.e., birth of a sibling, illness, geographic move, divorce)?

(5) Who first noticed or mentioned your child's stuttering?

(6) Did the stuttering start gradually or suddenly?

(7) Has your child been evaluated for stuttering or any other speech and language disorders by another professional? ____ If yes, what recommendations were you given?

(8) Has your child attended speech therapy in the past? ____ If so, what was the therapy for?

(9) Is your child currently enrolled in speech therapy? ____ If so, what is the purpose of the treatment?

(10) Please describe your child's initial and current stuttering (check all that apply):

Initial Stuttering Behaviors

_____ repetitions of first letters (b-b-boy)
_____ repetitions of whole words (boy-boy-boy)
_____ repetitions of parts of words (ca-ca-cat)
_____ prolongations of sounds (mmmmmom)
_____ silent blocks before speaking (-----boy)
_____ fillers (um, well, uh)
_____ changing words or starting over
_____ other _____ (please list)

Current Stuttering Behaviors

_____ repetitions of first letters (b-b-boy)
_____ repetitions of whole words (boy-boy-boy)
_____ repetitions of parts of words (ca-ca-cat)
_____ prolongations of sounds (mmmmmom)
_____ silent blocks before speaking (-----boy)
_____ fillers (um, well, uh)
_____ changing words or starting over
_____ other _____ (please list)

Initial Accompanying Behaviors

_____ eye blinking
_____ squeezing eyes shut
_____ looking away
_____ head nodding
_____ hand or foot movement
_____ breathing impacted
_____ other _____ (please list)

Current Accompanying Behaviors

_____ eye blinking
_____ squeezing eyes shut
_____ looking away
_____ head nodding
_____ hand or foot movement
_____ breathing impacted
_____ other _____ (please list)

(11) At the time that your child began stuttering, what was his/her reaction (i.e. awareness, concern, frustration, shame, indifference, avoidance, other)? Has this changed over time?

(12) When your child first began stuttering, how did you and other family members react when he/she was speaking? Has your reaction changed over time?

(13) How did your child respond to this reaction? (e.g., did he/she start talking more slowly, try saying it again, ignore it, get upset, stop talking, etc…?)

(14) Are there any situations where your child appears to stutter more often? Please explain.

(15) Are there situations where he/she appears to stutter less? Please explain.

(16) Were there any periods (days, weeks, months) when your child's stuttering either increased or decreased?

(17) Is your child's stuttering fluctuating currently, or is it pretty consistent in most situations?

(18) On a scale from one to ten, how concerned are each of this child's parents/caregivers? (Please only fill out for yourself, both parents should answer individually)

	Mildly concerned				Moderately concerned					Very concerned
Parent One	1	2	3	4	5	6	7	8	9	10
Parent Two	1	2	3	4	5	6	7	8	9	10
Other	1	2	3	4	5	6	7	8	9	10

(19) On a scale from one to ten, how would each of this child's parents rate the stuttering?

	Mild				Moderate					Severe
Parent One	1	2	3	4	5	6	7	8	9	10
Parent Two	1	2	3	4	5	6	7	8	9	10
Other	1	2	3	4	5	6	7	8	9	10

(20) What do you hope to gain from this evaluation?

(21) Are there any other speech and language concerns? If so, what are they?

(22) At what age (months) did your child:
_____ babble (e.g. 6 months, 10 months, etc.)
_____ jargon

_____ say first words
_____ 2-3 word combinations
_____ form sentences

Medical and Developmental History

(1) Please describe pregnancy and birth history (i.e. complications, type of delivery, prematurity, etc.).

(2) Please describe any developmental problems experienced during infancy or early childhood (i.e. late in walking, feeding issues, delayed language).

(3) List all illnesses, injuries, operations:

Date	Complications	Treatment	Physician

(4) Please note any current or past physical disabilities.

(5) Does your child receive occupational therapy? _____ (Y / N) physical therapy? _____ If yes to either or both, what is the purpose of the therapy?

(6) Has your child been tested for vision? _____ results? hearing? _____ results?

(7) Has your child had a history of ear infections? _____ If yes, give number of times per year and ages.

(8) Does your child take any medications? _____ (Y / N) Please list: _____

_____

(9) Family history of stuttering:

(It is helpful to ask relatives and your spouse about a possible history of stuttering)

	Mother	Father	Other Family Members
Ever stuttered? (Y / N)			
Still stutter?			
Had therapy?			
Outcome of therapy?			

Educational and Social History

(1) Name of the school your child currently attends:

(2) What grade is your child currently in?

(3) How old was your child when he/she started school?

(4) Does your child spend time in a regular classroom? _____ (Y / N)

(5) How did your child first cope with going to preschool or school?

(6) Do you have any concerns about your child's current school situation?

Are any changes planned?

(7) What feedback do you get from the school teachers/staff?

(8) At school, does your child currently have an Individualized Education Plan (IEP)? _____ (Y / N) If not, has he/she had one in the past? Please explain the services that are/were provided (i.e., speech therapy, physical therapy, occupational therapy, special instruction, etc…).

(9) Are the teachers concerned about the stuttering? _____ (Y / N)

How do teachers react to the stuttering?

(10) How does your child get along with other children (other than siblings)?

(11) Does your child have friends? _____ (Y / N) Does he/she see them outside of school? _____

If so, does your child interact with his/her friends in a typical, age-appropriate fashion? _____

(12) Is your child ever teased? _____ (Y / N) Ever bullied? _____ Ever get into fights? _____
Please explain:

Family History

(1) Parents:

	Name	Age	Highest grade completed	Occupation
Parent One				
Parent Two				

(2) How would you describe your family life and home environment?

(3) Siblings:

Children	Name	Age	Grade
1			
2			
3			
4			
5			

(4) How does you child get along with his/her siblings?

(5) During family conversations, how does he/she manage?

Behavior and Discipline

(1) Do both parents share discipline responsibilities for this child? Are you consistent?

(2) When this child needs discipline, what do you do?

(3) How does he/she respond?

(4) Is there anything that is currently difficult about managing your child's behavior? What about in the past?

Sensitivity/Regulation

(1) Compared to other children, how sensitive is your child in general?

	Not Sensitive		Slightly			Moderately			Highly Sensitive	
Sensitivity	1	2	3	4	5	6	7	8	9	10

(2) When your child becomes upset, is he/she able to calm down easily? (on average)

a. Yes, rather easily
b. Yes, but sometimes it takes a while
c. Sometimes, but he/she often cries or pouts for a long time before calming down
d. No, he/she has a very hard time calming down most of the time (i.e. tantrums)
e. Other: _____

(3) Compared to other children, how fearful is your child in general?

	Not Fearful		Slightly			Moderately			Highly Fearful	
Fearfulness	1	2	3	4	5	6	7	8	9	10