Stuttering Center of Western Pennsylvania
A partnership between the Department of Audiology and Speech-Language Pathology at Children's Hospital of Pittsburgh of UPMC and the Department of Communication Science and Disorders at the University of Pittsburgh

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Diagnostic Intake Form For Teens Who Stutter

Part I: PERSONAL INFORMATION

Name: _____ Check one: Male ____ Female ____

Date of Birth: _____ Age: _____

Home Address: _____ Home Phone: _____

_____ Grade / School: _____

Parents' Names: _____ Work Phone: _____

Siblings:

1. _____ Age: _____

2. _____ Age: _____

Part II: HISTORY OF SPEECH/LANGUAGE PROBLEMS

1. Please describe your speaking difficulty in your own words: _____

   _____

   _____

   _____

2. How long have you had this speaking difficulty? _____

   _____

3. How has the problem changed since it first began? _____

   _____

   _____

4. Have you previously been assessed for speech/language concerns? Yes No

   If so, please describe: _____

   _____

5. Have you previously received any speech/language therapy? Yes No

   If so, where? _____ By whom? _____

   For how long? _____ Focus of Treatment: _____

   Results of Treatment: _____

   _____

6. Have any other family members had speech/language problems? Yes No

   Please indicate the person's relationship to you and the nature of the problem. _____

   _____

7. How does stuttering affect your:

   Ability to participate in school activities? _____

   Ability to participate in social activities? _____

   Ability to interact with family members? _____

   Ability to interact with friends? _____

   Willingness to talk and communicate? _____

   Self-esteem or attitude toward self? _____

8. In what situations do you experience the greatest difficulty? _____

   _____

9. In what situations do you experience the least difficult? _____

   _____

10. What factors seem to affect your fluency the most? _____

    _____

11. What else do you think we should know about you or your stuttering? _____

    _____