



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

Stuttering Center of Western Pennsylvania

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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? (If so, please describe) _____

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):

| <u>At Home</u> | <u>At School</u> | <u>In New Situations</u> |
|----------------|------------------|--------------------------|
| 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):

| <u>At Home</u> | <u>At School</u> | <u>In New Situations</u> |
|----------------|------------------|--------------------------|
| 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. What else do you think we should know about your child (e.g., hobbies, interests, social skills)?

