American Institute for Stuttering
Speak freely. Live fearlessly.

27 West 20th Street, Suite 1203 · New York, NY 10011
(212) 633-6400 · www.stutteringtreatment.org

Adolescent & Teen Case History Form
Part 1: To be filled out by parent/guardian

Date: _____

Child's Name: _____ Age: _____ Grade: _____ Birthdate:_____

Parents: _____

Address (Street): _____ (Apt.) _____

City & State: _____ (Zip) _____

Parent's Phone: _____ Child's Phone: _____

Parent's Phone: _____ Other Phone: _____

Parent's Email Address: _____

Child's Email Address: _____

Child's Native Language(s): _____ Other Language(s): _____

Person Completing this form: _____

Relation (check one): ☐ Parent ☐ Other: _____

How did you hear about the American Institute for Stuttering? _____

_____

Health History

Health Problems: ☐ Yes ☐ No If yes, please explain: _____

Hearing Problem: ☐ Yes ☐ No If yes, please explain: _____

Vision: ☐ Normal ☐ Glasses ☐ Contacts

(check one if applicable) ☐ Nearsighted ☐ Farsighted ☐ Astigmatism

Operations (check all that apply): ☐ Tonsillectomy ☐ Ear ☐ Heart ☐ Other: _____
☐ Larynx (Throat) ☐ Eye ☐ Brain _____

Special Conditions: (check all that apply)
☐ Learning Disability ☐ Autism
☐ Cognitive Handicap ☐ ADD / ADHD
☐ Obsessive Compulsive Disorder ☐ Depression
☐ Psychological/Psychiatric Conditions ☐ Cerebral Palsy
☐ Other: _____
_____

Is your child currently taking any medications? ☐ Yes ☐ No
If yes, please list _____

Has your child received or is your child currently receiving counseling or psychotherapy? Yes☐ No ☐
If yes, please explain:

_____

_____

Your Child's Stuttering:

Description of Stuttering: ☐ Repetitions ☐ Prolongations ☐ Blocks ☐ Other

Secondary Physical Movements? (i.e., eye's closing, facial tension, hand movement, foot tapping): _____

_____

Specific Situations where stuttering is more severe: _____

_____

Specific words or sounds more challenging than others? (please list): _____

_____

Family History of stuttering?: ☐ Yes ☐ No

Please list family members who also stutter(ed):

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

At approximately what age did you first notice stuttering? _____

Please describe anything significant you recall about the onset of your child's stuttering.

_____

_____

How did you/your family respond when stuttering began?

_____

_____

How does your family currently respond to your child's stuttering?

_____

_____

Does your child have any other speech/language problems? ☐ Yes ☐ No

If yes, please explain: _____

How is your child doing academically?

_____

_____

What are your child's outside interests?

_____

_____

Previous Speech Therapy History

Has your child received any form of speech therapy in the past? ☐ Yes ☐ No

If yes, please indicate details below:

Type of Therapy	Amount of Time in Therapy	Age	Name of Therapist
Elementary School Speech Therapy			
Middle School Speech Therapy			
High School Speech Therapy			
Private Speech Therapist			

Please describe to the best of your knowledge what was addressed in therapy:

_____

_____

_____

_____

What are your concerns for your child at this time?

_____

_____

_____

_____

Please add anything you think will be helpful for us to know about your child.

_____

_____

_____

_____

Case History Information
Part 2: To be filled out by child/teen

Dear Teen,

The information you provide below will help us gain a better understanding of YOUR experience with stuttering. Please be as honest with us as possible. It is your choice whether you would like to show this to your parents or submit your responses directly to your therapist.

What do you remember about your stuttering early on?

_____

_____

How do you stutter? (check all that apply)

- ☐ I repeat sounds and parts of words
- ☐ I stretch/prolong sounds
- ☐ I have silent blocks
- ☐ I say lots of fillers such as “like” or “um”
- ☐ I stop before I stutter until I think I can say the word
- ☐ I push through my words using force or body movements (such as hand tapping, eye blinking)

Do you feel any tension in your face/body when you stutter? Explain.

_____

_____

Where do you speak most easily and freely?

_____

_____

_____

Where is it most difficult to speak?

_____

_____

_____

Your Reactions to Your Stuttering

What emotions do you feel when you stutter?

_____

_____

On a scale of 1 to 10, where 1 indicates no problem and 10 indicates a big problem, how much of a problem is your stuttering to you?

_____

What techniques/therapy approaches have you been taught in treatment?

- ☐ Never Had Therapy
- ☐ Fluency Shaping
- ☐ Stuttering Modification
- ☐ Pull-Outs
- ☐ Easy Onsets
- ☐ Prolongations
- ☐ Light Contacts
- ☐ Acceptance of Stuttering
- ☐ Desensitization
- ☐ Advertising/Self-Disclosure
- ☐ Voluntary Stuttering
- ☐ Delayed Auditory Feedback
- ☐ Preparatory Sets
- ☐ Meditation
- ☐ Slowed Speech
- ☐ Prolonged Speech
- ☐ Breathing Exercises
- ☐ Other _____
  _____
  _____

What was helpful/unhelpful to you in previous therapy?

Helpful: _____

_____

Not helpful: _____

_____

What are some of your hobbies/interests?

_____

_____

_____

What are things you want us to know about you that are important to you?

_____

_____

_____

Read each statement below. Place a check in the column that most closely matches how the statement applies to you.

	Agree	Sometimes	Disagree
1. There are certain words and sounds I avoid saying because I expect to stutter on them.			
2. I avoid some situations and conversations because I stutter			
3. I use fewer words to say what I need to say because of stuttering.			
4. I get out of talking by having others talk for me.			
5. I try to hide my stuttering by goofing around, acting shy, or acting like a bully.			
6. I use little tricks, or body movements, so I can get some words out.			
7. I add extra sounds or words such as “um” while I speak to keep my speech moving.			
8. When I stutter in front of strangers, I wonder if they are thinking something bad about me.			
9. My stuttering makes me look less smart to others than I really am.			
10. Stuttering makes it hard to make new friends.			
11. I would be embarrassed to talk about stuttering with other people.			
12. My grades in school would probably be better if I did not stutter.			
13. I feel that my stuttering upsets or bothers my parents but we don’t really talk about it.			
14. I worry if my speech will limit my job choices when I am older.			
15. My stuttering makes it harder for me to express my true feelings.			
16. My stuttering keeps me from having fun sometimes.			
17. Entering a new situation, I worry about how fluent my speech will be.			
18. I feel ashamed when I stutter a lot.			
20. People think I’m weird because of my stuttering.			

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Treatment and Observation Release Form

_____

Name of client

_____

Name of parent/guardian

☐ I give permission for the American Institute for Stuttering (AIS) to observe and videotape me and/or my child under the supervision of his/her clinician, by the treatment staff, and/or interns. The purpose of this observation is to advance the education and treatment of those who stutter.

☐ I do not give permission to AIS to observe and/or videotape me or my child.

_____ _____

Signature of parent/guardian Date

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Permission To Release/Obtain Information

Client's name: _____

*I hereby grant the American Institute for Stuttering to **request** information on my behalf from the following agencies/persons:*

Name: Address: Phone Number:

1. _____
_____
2. _____
_____

*I hereby grant the American Institute for Stuttering to **release** information on my behalf to the following agencies/persons:*

Same as above (check)

Name: Address: Phone Number:

1. _____
_____
2. _____
_____

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Caregiver Date
(if under 18)