american institute for stuttering

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

Adult Case History Form

Date: _____

Name: _____ Age: _____ Birthdate: _____

Address (Street): _____ (Apt.) _____

City & State: _____ (Zip) _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other Phone: _____

Email Address: _____

Marital Status (circle one): Single Married Widowed Separated Divorced Other

Education Level: _____

Occupation: _____

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

Person Completing this form: _____

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

Your Health

General Health (circle one): Excellent Fair Poor

Describe health problems: _____

Hearing Problem (circle one): Yes No If yes, please explain: _____

Vision (circle one): Normal Glasses Contacts

(circle one if applicable) Nearsighted Farsighted Astigmatism

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

Special Conditions: (check all that apply)

- ☐ Asthma
- ☐ Learning Disability
- ☐ Migraines
- ☐ Psychological/Psychiatric Conditions
- ☐ Other: _____
- ☐ Voice Disorder
- ☐ Mental Retardation
- ☐ Cerebral Palsy
- ☐ Drug/Alcohol Dependency

Currently or in the past, tried taking medications to treat stuttering (prescription or over the counter)? Yes No
If Yes, which medications have been tried? _____

Currently taking any medications? Yes No
Current Medications and what are they for? _____

Have you received or are you currently receiving some form of counseling or psychotherapy? Yes No
If yes, please explain: _____

Your 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 particularly challenging: _____

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

Family History of Stuttering (circle one) 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 your stuttering begin? _____ (ask a parent, when possible)

Was the onset of your stuttering . . . sudden or gradual? (circle one)

Were there any stressful life events that occurred around the time your stuttering began? Yes No
If yes, please explain: _____

Other Speech/Language Problems (circle one): Yes No
If yes, please explain: _____

Previous Therapy History

Have you received any form of speech therapy for your stuttering 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			
College Speech Clinic			
Psychotherapy			
Drug Therapy			
Private Speech Therapist			
Intensive Treatment Program If so, which one? _____			

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

- ☐ Fluency Shaping
- ☐ Stuttering Modification
- ☐ Delayed Auditory Feedback
- ☐ Speech Control
- ☐ Prolongations
- ☐ Light Contacts
- ☐ Preparatory Sets
- ☐ Speech Motor Training
- ☐ Gradual Increase in Length and Complexity of Utterance (GILCU)
- ☐ Shadowing
- ☐ Vocal Fold Management
- ☐ Slowed Speech
- ☐ Relaxation
- ☐ Voluntary Stuttering
- ☐ Advertising/Self-Disclosure
- ☐ Prolonged Speech
- ☐ Pull-Outs
- ☐ Easy Relaxed Approach – Smooth Movements (ERA-SM)
- ☐ Metronome Conditioned Speech Retraining (MCSR)
- ☐ Acceptance of Stuttering
- ☐ Desensitization
- ☐ Air Flow
- ☐ Meditation
- ☐ Easy Onsets
- ☐ Hypnosis
- ☐ Regulated Breathing
- ☐ Timeout From Speaking
- ☐ Other _____
  _____
  _____

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

***IMPORTANT**: In order to for us to best serve you, persons who apply for participation in treatment must indicate any drug use, psychiatric condition, learning disability and/or other relevant current medical conditions so that an appropriate assessment may be made regarding one's ability to participate in therapy.

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)