Pediatric Stuttering Assessment Template

Demographics

Name: ____

Date of Birth: _____________ Date of Assessment: __________________ Age: ______

Gender: M / F

Home Address: ______________________________ Primary Phone: __________________

City, State, Zip _______________________________ Primary E-Mail: __________________

Parent(s) / Guardian(s)

Mother: ____________________ Day Phone: ______________________

Address (if different from above): ____

Father: ____________________ Day Phone: ______________________

Address (if different from above): ____

Other People in the Household:

Name	Age	Relationship
_______________________	__________________	___________________
_______________________	__________________	___________________
_______________________	__________________	___________________
_______________________	__________________	___________________
_______________________	__________________	___________________
_______________________	__________________	___________________

Background

Referred by: ____

Reason for Referral: ____

Is there a family history of persistent stuttering?   Y / N

If so, explain: ____

Is there a family history of recovered stuttering?   Y / N

If so, explain: ____

How long has it been since the child started stuttering? ______________________________

____

How has the stuttering changed (if at all) since it first started? _________________________

____

Which of the following behaviors do you hear/see your child demonstrating?

□ Repeating short phrases (e.g., “I want, I want, I want juice.”)

□ Repeating whole words (e.g., “Can can can I have some?” or “When, when, when is it?”)

□ Starting to talk and revising what they want to say (e.g., “My dad, my mom, my family went to the park.”)

□ Repeating the initial sounds of words (e.g., “C-Can I go?” or “S-S-Sing a song.”)

□ Prolonging or stretching out sounds (e.g., “Mmmmmy name” or “Siiiiiister”)

□ Blocking on sounds (e.g., “-------I like ice cream” or “Listen ------to me”)

□ Extra words or fillers (e.g., *um, uh, like*)

Has your child ever demonstrated any . . .

□ awareness of stuttering?   □ physical tension during stuttering?

□ frustration about speaking?   □ complaints that they “can’t talk”?

Describe: ____

____

Has your child ever been teased about stuttering? Y / N

If yes, explain: ____

____

Has your child ever discussed his/her stuttering with you? Y / N

If yes, explain: ____

____

Are there situations where your child seems to stutter less? Y / N

If yes, explain: ____

____

Is English the only language your child uses? Y / N

If no, what other language does your child use? ____

____

At what age did your child start learning/speaking this language?

____

At what age did your child start learning/speaking English?

____

Medical and Developmental History

Was there anything remarkable about the mother's health during pregnancy or delivery? Y / N

If yes, explain: ____

____

Was there anything remarkable about your child's condition at birth? Y / N

If yes, explain: ____

____

Does your child have any current health or medical concerns? Y / N

If yes, explain: ____

____

Is your child currently taking any medication? Y / N

If yes, what medication(s)? ____

____

Does your child have any allergies? Y / N

If yes, describe: ____

____

Does your child have developmental concerns? Y / N

If yes, check any of the following concerns that apply:

□ Learning disability	□ Cognitive impairment	□ Behavior
□ Attention/focusing	□ Peer interactions	□ Other

Describe the concerns in greater detail here, if necessary: ______________________________

____

Has your child's hearing ever been tested? Y / N

If yes, what were the results? ____

____

How often do the following behaviors occur? Please circle one per item. (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

How would you describe your child's overall temperament?

____

____

____

Stuttering/Speech/Language

Has your child previously been assessed for speech/language concerns? Y / N

If yes, describe: ____

____

Has your child received any prior speech/language therapy? Y / N

If yes, where? _______________________ By whom? _________________________________

For how long? ______________________ Treatment focus: ____________________________

Treatment results: ____

Have any other family members had speech/language treatment? Y / N

If yes, indicate the person's relationship to your child and the nature of the problem. ______________

____

Rate how often your child is able to speak fluently in the following situations (circle one per column):

At Home	At School	In New Situations
Always	Always	Always
Almost Always	Almost Always	Almost Always
Sometimes	Sometimes	Sometimes
Rarely	Rarely	Rarely
Never	Never	Never

Rate how often your child is able to speak without his or her stuttering affecting overall communication:

At Home	At School	In New Situations
Always	Always	Always
Almost Always	Almost Always	Almost Always
Sometimes	Sometimes	Sometimes
Rarely	Rarely	Rarely
Never	Never	Never

How does your 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? ____

What do other family members do when they hear your child stutter?

____

What do you think will help your family manage the stuttering better?

____

Has the teacher noticed your child's stuttering?

□ No

□ Yes (and he or she approached the family with concerns)

□ Yes (after being asked directly by the family)

Does your child currently receive treatment for stuttering? Y / N

If yes, where? ____

What goals/outcomes do you have for the child in therapy?

____

____

What else do you think we should know about your child (e.g., hobbies, interests, social skills)?

____

____

____

____

Assessment

Behavioral Assessment

Tests Administered: ____

Results: ____

Disfluency Rate: ____

Secondary Behaviors (list): ____

Physical tension:

□ Mild □ Mild–Moderate □ Moderate □ Moderate–Severe □ Severe

Describe: ____

Affective/Cognitive Assessment

Tests Administered: ____

Results: ____

Disfluency Rate: ____

Secondary Behaviors (list): ____

Physical tension:

□ Mild □ Mild–Moderate □ Moderate □ Moderate–Severe □ Severe

Describe: ____

Impact on Educational Participation:

□ Mild □ Mild–Moderate □ Moderate □ Moderate–Severe □ Severe

Describe: ____

____

What goals/outcomes would the child like to achieve in therapy?

____

____

____

____

Prognosis for effective management of stuttering:

□ Good □ Fair □ Poor

Based on: ____

Recommendations: ____

____

Other Suggested Referrals: ____

____

Follow-Up Plan: ____

____

____

____

____