



Adult Fluency Case History Form

Name: _____ Primary Language: _____

Address: _____ Referred By: _____

Primary Doctor: _____

Phone: _____ Phone: _____

Age: _____

Date of Birth: _____

Please describe your speech: _____

What information do you hope to obtain from this evaluation? _____

Do you have trouble with any of the following? Please circle all that apply.

Finding the right word Getting to the point Organizing your thoughts

What motivated you to seek advice or help regarding your speech? _____

FAMILY HISTORY

Is there a family history of stuttering or any other speech, language, learning, reading, attention, or hearing problems? If yes, please describe.

MEDICAL HISTORY

As far as you know, was your speech and language development normal?

Please describe any difficulties: _____

How is your present health ? Good _____Fair _____Poor _____

Have you ever been hospitalized? _____

Do you have any chronic or current medical problems? If yes please list

Are you presently taking medication? If yes, please list

FLUENCY PROBLEM

A. Onset

1. When was the problem first noticed? _____

2. By Whom? _____

3. What do you believe caused the problem? _____

B. Type of Stuttering

1. Please check or describe symptoms which apply to your stuttering:

- _____ Repetitions of sounds (“I want the b-b-b-all.”)
- _____ Repetitions of single syllable words (“ I-I-I-I want to go.”)
- _____ Repetitions of syllables (“So-so-so-soldier”)
- _____ Repetitions of entire words (“I want-want-want the ball.”)
- _____ Repetitions of phrases (“I want -I want -I want to go.”)
- _____ Prolongation of sounds (“sssssssssoldier”)
- _____ Use of “filler words” (“um,” “and then,” “you know”))
- _____ Faulty Breathing Describe: _____

_____ Changes in loudness. Describe: _____

_____ Facial movements. Describe: _____

_____ Hand movements. Describe: _____

_____ Other body movements. Describe _____

_____ Struggle and tension during speech. Describe: _____

Other. Describe: _____

2. Describe any changes in the problem since it began? _____

3. If possible, list three situations in which you have noticed the speech problem is worse than usual.

- a. _____
- b. _____
- c. _____

4. If possible, list three situations in which you have noticed the speech problem is better than usual.

- a. _____
- b. _____
- c. _____

5. List any persons around whom you have greater difficulty talking and their relationship to you.

- a. _____
- b. _____
- c. _____

6. List any persons around whom you have the least difficulty talking and their relationship to you.

- a. _____
- b. _____
- c. _____

7. What is your typical reaction to your fluency problem?

9. List prior treatment for your dysfluent speech.

<u>When</u>	<u>Where</u>	<u>How Long?</u>	<u>Advice/Type of Therapy</u>

10. How often do you stutter?

11. Do you have periods of time when you do not stutter?

a. How long do they last? _____

b. Are they related to who is listening? _____

c. Are they related to what you are talking about? _____

d. Are they related to your physical state at the time? _____

e. Are they related to your emotional state? _____

12. Once a stuttering episode has started, do you try to stop it? If so, how?

SOCIAL HISTORY

1. What is your occupation? Briefly explain your job responsibilities.

2. Who do you live with? Please include ages of children, if applicable.

3. Please list any hobbies or interests

Additional Comments/Information: _____

FINANCIAL RESPONSIBILITY

I hereby agree to accept full responsibility for all fees for services rendered to the patient by the practitioner. I am also aware of the cancellation policy enclosed.

Signed: _____ Date: _____

Driver's License Number: NJ _____

CANCELLATION POLICY

Princeton Speech and Language Center is dedicated to providing quality services to our clients. We must stress that consistency of attendance is crucial in order for clients to effectively meet the goals of their treatment plan. In addition, therapy time is specifically reserved for your family and is unavailable for other clients.

We are sensitive to the needs faced by the families of our clients however; it is necessary for us to enforce a cancellation policy. Except in cases of emergency or sudden illness, appointments not cancelled **48 hours** in advance will result in a charge as though the appointment was held.

We look forward to a positive relationship with you, as we strive to provide cutting edge, quality treatment and specialized programs. Thank you for your attention to this matter.

Signed: _____

Date: _____

CLINICAL RELEASE OF INFORMATION

Mr.

Mrs.

I, Ms. _____, hereby give Princeton Speech-Language & Learning Center permission to discuss my case with the interdisciplinary professionals involved in my care, and to release any relevant clinical information to those professionals if requested. I also authorize PSLLC to release and/or share any information requested by my insurance company.

(Client's Name)

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Signature of Patient: _____ Date: _____

Document must be signed by parent or guardian if patient is under 18 years of age.