

**SPEECH PATHWAYS, PC**

**FLUENCY HISTORY**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **e-mail:** \_\_\_\_\_

First

Middle

Last

City

State

Zip

**Telephones:** Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Age:** \_\_\_\_\_ **Sex:** M\_\_ F\_\_ **Marital Status:** \_\_\_\_\_

**Name of spouse or nearest relative:** \_\_\_\_\_

**Address (if different from yours):** \_\_\_\_\_

**Social Security #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Medicare/Medicaid #** \_\_\_\_\_

**Referred by:** \_\_\_\_\_

**Educational level:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Employed by:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**List and describe all members of your present family living in your home, and any speech, hearing or language problems present.**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Communication problem:** \_\_\_\_\_

**YOUR CURRENT HEALTH STATUS: (Circle Y or N; explain more fully when appropriate)**

**Are you currently in good health?** Y N \_\_\_\_\_

**Is your hearing good?** Y N \_\_\_\_\_

**Is your vision good?** Y N \_\_\_\_\_

**Are you ambulatory?** Y N \_\_\_\_\_

**Are you currently taking medications?** Y N (If yes, please list) \_\_\_\_\_

**Do you have any associated medical pathology (e.g., cleft palate, cerebral palsy, post-CVA, accident or**

**injury) which may be contributing to your stuttering problem? Y N (If so please explain below)**

\_\_\_\_\_

\_\_\_\_\_

**Have you been hospitalized within the past year? Y N If so, may we contact your hospital for your discharge summary? (Signed) \_\_\_\_\_**

**(Name of hospital) \_\_\_\_\_**

**If, in order to help you, it may be appropriate to send reports to or contact other agencies or professional persons for information. Please indicate your permission by signing below.**

**I authorize and request \_\_\_\_\_**

**(Clinic**

**name and address)**

**to obtain and/or exchange pertinent medical /educational information. It is understood that all information will be kept confidential.**

**Signed: \_\_\_\_\_ Date: \_\_\_\_\_**

**If signed by a person other than the client, please give name and relationship of that person below:**

**YOUR SPEECH, LANGUAGE OR HEARING PROBLEM:**

**Why are you seeking help at this time? \_\_\_\_\_**

**How long have you had this problem? \_\_\_\_\_ Have you ever received treatment? Y N**

**If so, where? \_\_\_\_\_ For how long? \_\_\_\_\_**

**Describe the strategies that helped: \_\_\_\_\_**

**Describe those you tried that did not help: \_\_\_\_\_**

**What does your stuttering sound like to you? \_\_\_\_\_**

**Repeated sounds \_\_\_ words \_\_\_ Prolonged sounds \_\_\_ Holding breath \_\_\_ Sounds get stuck \_\_\_**

**When is the problem better? \_\_\_\_\_**

**When is it worse? \_\_\_\_\_**

**What do you think caused the problem? \_\_\_\_\_**

**How do you feel about the problem? \_\_\_\_\_**

**Do you avoid speaking at times? Y N (Please explain) \_\_\_\_\_**

**What**

**are the reactions of others to the problem? \_\_\_\_\_**

**Does the problem affect your job \_\_\_ school performance \_\_\_ (Please explain) \_\_\_\_\_**

\_\_\_\_\_

**Does any member of your family have a similar problem? \_\_\_\_\_**

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**In the space below, please provide any additional information that may be useful in evaluating your communication and planning a treatment program:**

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