



**The Stuttering Center of Western Pennsylvania**

**J. Scott Yaruss, Ph.D. CCC-SLP**  
(412) 383-6538, [jsyaruss@csd.pitt.edu](mailto:jsyaruss@csd.pitt.edu)

**Craig Coleman, M.A., CCC-SLP**  
(412) 666-3825, [Craig.Coleman@chp.edu](mailto:Craig.Coleman@chp.edu)

**Referrals: (412) 692-5575 (Children's Hospital, Oakland)**  
Website: [www.stutteringcenter.org](http://www.stutteringcenter.org)

**Diagnostic Intake Form for Preschool and School-Age Children**

**Child**

Name: \_\_\_\_\_

Check one: Male \_\_\_ Female \_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

City, State Zip \_\_\_\_\_

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

**Parent(s) / Guardian(s)**

Mother: \_\_\_\_\_ Occupation: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Father: \_\_\_\_\_ Occupation: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

**Other People in the Household:**

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

***History of Speech/Language Problems***

1. Describe your child's speaking difficulty in your own words: \_\_\_\_\_  
\_\_\_\_\_
2. At what age was this problem first noticed? \_\_\_\_\_
3. Who first noticed the problem? \_\_\_\_\_
4. How has the problem changed since that time? \_\_\_\_\_  
\_\_\_\_\_
5. Do you have difficulty understanding your child? \_\_\_\_\_
6. Do other people have difficulty understanding your child? \_\_\_\_\_

7. Has your child previously been assessed for speech/language concerns? Yes    No

If so, describe: \_\_\_\_\_  
\_\_\_\_\_

8. Has your child received any prior speech/language therapy? Yes    No

If so, where? \_\_\_\_\_ By whom? \_\_\_\_\_

For how long? \_\_\_\_\_ Focus of Treatment: \_\_\_\_\_

Results of Treatment: \_\_\_\_\_

9. Have any other family members had speech/language problems? Yes    No

Indicate the person's relationship to the child and the nature of the problem. \_\_\_\_\_

\_\_\_\_\_

### ***Medical History and Current Health Status***

1. Was there anything remarkable about the mother's health during pregnancy or delivery? \_\_\_\_\_

\_\_\_\_\_

2. Was there anything remarkable about the child's condition at birth? \_\_\_\_\_

\_\_\_\_\_

3. Does the child have developmental concerns other than the speech/language problem? Yes    No

Describe \_\_\_\_\_

\_\_\_\_\_

4. At approximately what age did your child begin to:

walk \_\_\_\_\_ use words \_\_\_\_\_ combine words \_\_\_\_\_

5. Has your child experienced ear infections? Yes    No

Approximately how often (circle one)? Rarely Occasionally Frequently

Has your child's hearing ever been tested? Yes    No Results \_\_\_\_\_

Do you feel your child hears normally? Yes    No Explain \_\_\_\_\_

6. Indicate if your child has experienced the following medical problems.

Chicken Pox \_\_\_\_\_ Tonsillitis \_\_\_\_\_ Vision Problems \_\_\_\_\_

Pneumonia \_\_\_\_\_ Headaches \_\_\_\_\_ High Fever \_\_\_\_\_

Seizures \_\_\_\_\_ Allergies \_\_\_\_\_ Asthma \_\_\_\_\_

7. Describe illnesses, accidents, injuries, hospitalizations (include age/treatment): \_\_\_\_\_  
\_\_\_\_\_

8. How often do the following behaviors occur? (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 |

9. What is your child's current health?                      good \_\_\_\_\_      fair \_\_\_\_\_      poor \_\_\_\_\_

Is your child currently taking any medication?      Yes      No      If so, what? \_\_\_\_\_

Does your child have any other medical diagnoses or concerns? \_\_\_\_\_  
\_\_\_\_\_

### ***Speech Fluency and Stuttering***

1. When did your child first start stuttering? (Be as specific as possible.) \_\_\_\_\_  
\_\_\_\_\_

2. What did the stuttering sound like when it first began? \_\_\_\_\_  
\_\_\_\_\_

3 Describe how your child's speech sounds now. \_\_\_\_\_  
\_\_\_\_\_

4. What seems to help your child when he or she is stuttering? \_\_\_\_\_  
\_\_\_\_\_

5. Has your child ever demonstrated any:

awareness of stuttering                      \_\_\_\_\_      physical tension during stuttering                      \_\_\_\_\_

frustration about speaking                      \_\_\_\_\_      complaints that s/he "can't talk"                      \_\_\_\_\_

Describe \_\_\_\_\_  
\_\_\_\_\_

6. Has your child ever been teased about stuttering?                      Yes      No

Describe \_\_\_\_\_  
\_\_\_\_\_

7. Has your child ever discussed his/her speaking difficulties with you? Yes    No

Describe \_\_\_\_\_  
\_\_\_\_\_

8. Is there any history of stuttering in the family? \_\_\_\_\_

Do any of the child's parents, brothers, or sisters stutter? \_\_\_\_\_

Anyone on child's mother's side? \_\_\_\_\_ Anyone on child's father's side? \_\_\_\_\_

Describe the relative(s)' stuttering. \_\_\_\_\_  
\_\_\_\_\_

9. Have you or your child ever known another person who stutters? Yes    No

Who? \_\_\_\_\_

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

<u>At Home</u>	<u>At School</u>	<u>In New Situations</u>
Always	Always	Always
Almost Always	Almost Always	Almost Always
Sometimes	Sometimes	Sometimes
Rarely	Rarely	Rarely
Never	Never	Never

11. Rate how often your child is able to speak freely, regardless of fluency (circle one in each column):

<u>At Home</u>	<u>At School</u>	<u>In New Situations</u>
Always	Always	Always
Almost Always	Almost Always	Almost Always
Sometimes	Sometimes	Sometimes
Rarely	Rarely	Rarely
Never	Never	Never

12. How does the 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? \_\_\_\_\_

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

\_\_\_\_\_

14. If you would like to receive the Stuttering Center's e-Newsletter, please provide your email address:

\_\_\_\_\_