

**Case History Form for Children with Suspected or Confirmed Stuttering**

1. When did you first notice your child's fluency difficulties? (Month, year) \_\_\_\_\_  
\_\_\_\_\_
2. How has your child's speech changed since the concerns were first noticed? \_\_\_\_\_  
\_\_\_\_\_
3. How does your child sound or look when s/he has difficulty speaking fluently now? \_\_\_\_\_  
\_\_\_\_\_
4. In what situations does your child have the *most* difficulty with speaking fluently? \_\_\_\_\_  
\_\_\_\_\_
5. In what situations does your child have the *least* difficulty with speaking fluently? \_\_\_\_\_  
\_\_\_\_\_
6. Is there anything that seems to aggravate your child's fluency problems? \_\_\_\_\_  
\_\_\_\_\_
7. Is your child aware of his/her difficulties? If yes, what does your child do to show you they are aware? Does he/she show signs of frustration? \_\_\_\_\_  
\_\_\_\_\_
8. Does your child show any of the following during disfluencies? (please check)

Tension in face/body/arms/legs	
Extra movements in face/body/arms/legs	
Rhythmical movements (blinking, rocking)	
Changes in volume	
Out of breath/loud breathing	
Unusually fast/slow speech	
Avoiding/altering words used	

9. Do any of your child's relatives have a history of stuttering?

Relative?	Age when stuttering began	Does the person still stutter?	Age when stuttering stopped (if it did):
		Yes No	
		Yes No	
		Yes No	

10. What do you hope to achieve with speech therapy for fluency? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_