# 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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
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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., “Mmmmmmy 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):

<table>
<thead>
<tr>
<th>At Home</th>
<th>At School</th>
<th>In New Situations</th>
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</thead>
<tbody>
<tr>
<td>Always</td>
<td>Always</td>
<td>Always</td>
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<tr>
<td>Almost Always</td>
<td>Almost Always</td>
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<tr>
<td>Sometimes</td>
<td>Sometimes</td>
<td>Sometimes</td>
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<tr>
<td>Rarely</td>
<td>Rarely</td>
<td>Rarely</td>
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<tr>
<td>Never</td>
<td>Never</td>
<td>Never</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>At Home</th>
<th>At School</th>
<th>In New Situations</th>
</tr>
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<td>Never</td>
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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: _________________________________________

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________