OTTESEN THERAPIES

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Child Name:_____

Date of Birth: _____ Age: _____

Home Address: _____ Home Phone: _____

City, State Zip_____ Referred by: _____

Parent(s) / Guardian(s)

Parent: _____ Occupation: _____ Day Phone:_____

Address (if different from above):_____

Parent: _____ 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

1. When did your child first start experiencing disruptions in speech flow? (Be as specific as possible.)

_____

_____

2. What did this 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 dysfluent?

_____

_____

5. Has your child ever demonstrated any:

awareness of disruptions in the flow of speech _____ physical tension during dysfluent moments _____

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

Describe _____

_____

6. Has your child ever been teased about speech disruptions? 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/cluttering in the family? _____

Anyone on child's mother's side?_____ Anyone on child's father's side?_____

Describe this. _____

_____

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

Who? _____

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

At Home:	*Always*	*Almost Always*	*Sometimes*	*Rarely*	*Never*
At School:	*Always*	*Almost Always*	*Sometimes*	*Rarely*	*Never*
New Situations:	*Always*	*Almost Always*	*Sometimes*	*Rarely*	*Never*

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

At Home:	*Always*	*Almost Always*	*Sometimes*	*Rarely*	*Never*
At School:	*Always*	*Almost Always*	*Sometimes*	*Rarely*	*Never*
New Situations:	*Always*	*Almost Always*	*Sometimes*	*Rarely*	*Never*

12. How does the child's dysfluency affect his/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)?