Elena A. Caffentzis, M.S., CCC-SLP, BCS-F
SPEECH JOURNEY
Speech-Language Pathologist
111 North Central Ave. Suite 300 • Hartsdale, NY 10530
(914) 907-7231 • elena@speechjourney.com

ADULT CASE HISTORY FORM

Please complete and return this form at our first meeting along with copies of any previous evaluations.

Name: ______________________________ Today's Date: ____________________

Person filling out form: ____

Relationship to client: ____

Birthdate: ______________________________

Mailing Address: ____

____

Cell # ______________________________ Home #____________________

Email: ____

Highest grade completed/degree(s) earned: ___________________________

Are you currently employed? What is your occupation? ____________________

____

Circle one: *Right-Handed* / *Left-Handed* / *Ambidextrous*

Marital Status ____

Names/ages of Individuals living in your home: _________________________

Names and ages of your children (if any): ______________________________

Emergency contact name and #: ____________________________________

Referred By: ____

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SPEECH AND LANGUAGE HISTORY:

Please explain your current speech and language issues and the reason for this evaluation:

____

____

____

Is English your first language? *Yes* / *No* Are you bilingual? *Yes* / *No*

What was the approximate age that you began having difficulty with fluency?

____

Are you currently receiving or have you received speech therapy in the past? If so, please describe your experience and your age(s) when you received therapy:

____

____

When was the disfluency first noticed? By whom? What do you believe caused the onset?

____

____

Please note your current disfluency patterns (check all that apply):

Current Disfluency Behaviors

	repetitions of the first letter (b-b-boy)
	repetitions of the whole word (boy-boy-boy)
	repetitions of part of the word (ca-ca-cat)
	prolongations of sounds (mmmmmom)
	silent blocks before speaking (-----boy)
	fillers (um, well, uh)
	changing words or starting over
	other

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Please note your current physical behaviors observed during speech (check all that apply):

Current Physical Behaviors

	eye blinking
	head nodding
	hand or foot movement
	difficulty breathing
	squeezing eyes shut
	looking away
	tension
	other (list)

Please describe your current reactions to your disfluencies:

Current Reactions

	awareness
	frustration
	shame
	indifference
	avoidance
	other

Are there any periods (days, weeks, months) when stuttering either increases or decreases? If possible, list three situations (i.e. people, places, times) when disfluencies increase or decrease.

Does your stuttering fluctuate or remain consistent?

Would you describe your speech difficulty as mild, moderate or severe?

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What do you hope to gain from this evaluation?

Do you have any other speech and language concerns?

MEDICAL, DEVELOPMENTAL, AND FAMILY HISTORY

To the best of your knowledge, was your speech and language development on target? If not, please describe any difficulties or delays:

How is your present health? (circle one) *Excellent* *Good* *Fair* *Poor*

Have you ever been hospitalized? If yes, please explain:

Do you have any chronic or current medical problems? If yes, please list:

Are you presently taking supplements and/or medications? If yes, please list name, frequency, and dosages:

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Family history of stuttering:
(It is helpful to ask relatives about a possible history of stuttering.)

	Mother	Father	Other Family Members
Ever stuttered? (Y/N)			
Still stutter?			
Had therapy?			
Outcome of therapy?			

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Treatment and Observation Release Form

____
Name of client

____
Signature of client

☐ I give permission for Speech Journey to observe and videotape me under the supervision of your clinician, by the treatment staff, and/or interns. The purpose of this observation is to assess you and to advance the education and treatment of those who stutter.

☐ I do not give permission to Speech Journey to observe and/or videotape me.

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Client's name: ____

I hereby grant permission to Speech Journey to release information on my behalf to the following agencies/persons:

**Please include the name, address, and phone of your physician or other medical professionals so that we can educate and inform your doctor about stuttering treatment and about the specifics of your case.*

1. ____

____

2. ____

____

I hereby grant permission to Speech Journey to request information on my behalf from the following agencies/persons:

1. ____

____

2. ____

____

______________________________ ______________
Client Signature Date

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Speech Journey Therapy Guidelines & Cancellation Agreement

Sessions:

- Sessions are usually one hour in length, which includes any time necessary for parent consultation, scheduling and billing issues.

Commitment/Scheduling:

- Your treatment and care are of the utmost importance to me and I value nurturing a mutually respectful relationship with you and your family. A strong commitment to the process is essential for steady progress.
- Once a session is scheduled, **24-hour notice is required for any cancellation or postponements.** ***Clients will be charged in full for any session cancelled less than 24-hours in advance.*** I will do my best to accommodate a makeup session. However, if we cannot find a mutually desirable time to reconvene within a one-week period, it will be considered a cancellation and the full session fee will be charged.
- Occasionally, I may ask if you can move a session time. Please know if I am doing so, it is probably because I am trying to accommodate another client and that *your scheduled session* comes first.

Billing:

- Payments may be made via cash or check (made out to "Speech Journey"), or other electronic means (Venmo, Square Cash, Zelle, Apple Pay, Google Wallet, etc). There will be a $35 fee charged for any returned checks.
- Insurance reimbursement may be possible. You will be provided with receipts of payment to submit to your insurance company. It is your responsibility to inquire about your plan's benefits. Our office will provide whatever assistance we can in helping you receive the benefits to which you are entitled, however, you (not your insurance company) are responsible for full payment of my fees.

Your signature below indicates that you have read this agreement and agree to its terms.

Client name: ______________________________

Signature of Client or Parent/Guardian: ______________________________

Date: ______________________________