Elena A. Caffentzis, M.S., CCC-SLP, BCS-F
Speech-Language Pathologist
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PEDIATRIC CASE HISTORY FORM

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

Child's Name: _____ Today's Date: _____

Child's Nickname/Prefer to be called: _____

Child's Birthdate: _____

Mailing Address: _____

_____

	Parent 1	**Parent 2**
Name		
Cell #		
Home #		
Email		
Age		
Highest grade completed		
Occupation		
Handedness		

Person filling out form name & relationship to child: _____

Emergency contact name & phone #: _____

Referred By: _____

Child's school & grade: _____

Teacher's Name: _____

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SPEECH AND LANGUAGE HISTORY:

Please describe your child's current speech and language skills and any concerns you have:

Is English your child's first language? Yes / No

Are you bilingual? Yes / No

Is your child bilingual? Yes / No
If yes, does your child stutter more in one language than another? Please explain.

List all languages spoken at home:

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

Who first noticed or mentioned stuttering?

Did the stuttering start gradually or suddenly?

Were there any precipitating factors that you suspect may have been associated with the onset of disfluency (i.e. birth of a sibling, illness, geographic move, divorce)?

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Has another professional evaluated your child for speech? If yes, what recommendations were you given?

Is your child currently attending speech therapy or has s/he attended in the past? If so, what was being treated?

Please describe your child's initial and current disfluency patterns (check all that apply):

Initial 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

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

Please describe your child's initial and current physical behaviors observed during speech (check all that apply):

Initial Physical Behaviors

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

Current Physical Behaviors

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

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Please describe your child's initial and current reactions to his/her disfluencies:

Initial Reactions

	awareness
	frustration
	shame
	indifference
	avoidance
	other

Current Reactions

	awareness
	frustration
	shame
	indifference
	avoidance
	other

When your child ***first began stuttering***, how did you and other family members react when s/he was speaking? (e.g. did anyone tell him to take his time, slow down, calm down, take a breath, or did you and family members give him as much time as he needed, etc…..?) How did your child respond to this reaction? (e.g., did s/he start talking more slowly, try saying it again, ignore it, get upset, stop talking, etc….?)

How do you and other family members ***currently*** react when s/he was speaking? How does your child respond to this current reaction?

Are there any periods (days, weeks, months) when stuttering either increase or decrease? List any situations (i.e. people, places, times) when your child's disfluencies increase or decrease.

Does your child's stuttering fluctuate or remain consistent?

How concerned are you and your family about your child's disfluent speech? How concerned does your child appear to be?

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

What do you hope to gain from this evaluation?

Are there any other speech and language concerns?

At what age did your child: (e.g. 6 months, 10 months, etc.)

	babble
	jargon
	say first words
	2-3 word combinations
	form sentences

MEDICAL, DEVELOPMENTAL, AND FAMILY HISTORY

Please describe pregnancy and birth history (i.e. complications, type of delivery, prematurity, etc.).

Please describe any developmental problems experienced during infancy or early childhood (i.e. late in walking, feeding issues, delayed language).

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List all illnesses, injuries, operations:

Date	Treatment	Complications	Physician

Please note any current physical disabilities:

Does your child receive: occupational therapy? Y / N physical therapy? Y / N
What is the purpose of therapy?

Has your child's vision been tested? What were the results?

Has your child been tested for hearing? What were the results?

Has your child had a history of ear infections? If yes, give number of times per year and ages.

What hand does your child use most often?
_____right _____left _____both

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Does your child take any medications? Please list.

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

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

EDUCATIONAL AND SOCIAL HISTORY

How old was your child when he/she started school?

Does your child spend time in a regular classroom? Y / N

How did your child first cope with going to preschool or school?

Do you have any concerns about your child's current school situation?

What feedback do you get from the school teachers/staff?

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At school, does your child currently have an Individualized Education Plan (IEP)? Y / N
If not, has s/he had one in the past? Please explain the services that are/were provided (i.e., speech therapy, physical therapy, occupational therapy, special instruction, etc…).

How does your child get along with other children (other than siblings)? Does he/she see them outside of school? If so, does your child play with his/her friends in a typical, age-appropriate fashion?

Is your child ever teased or bullied or get into fights?

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FAMILY HISTORY

Children

Name	Age	Grade	Handedness

How does your child get along with his/her siblings?

During family conversations, how does s/he manage?

How would you describe your home life and family environment?

BEHAVIOR AND DISCIPLINE

Do both parents share discipline responsibilities for this child? Are you consistent?

When this child needs discipline, what do you do?

How does s/he respond?

Is there anything that is currently difficult about managing your child's behavior? What about in the past?

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TEMPERAMENT

Compared to other children, describe your child:

	None		Slightly		Moderately			Highly		
Sensitivity	1	2	3	4	5	6	7	8	9	10
Fearfulness	1	2	3	4	5	6	7	8	9	10

When your child becomes upset, is s/he able to calm down easily? (on average)
a. Yes, rather easily
b. Yes, but sometimes it takes a while
c. Sometimes, but s/he often cries or pouts for a long time before calming down
d. No, s/he has a very hard time calming down most of the time (i.e. tantrums)
e. Other: _____

Compared to other children, generally how fearful is your child?

	Not Fearful		Slightly		Moderately			Highly Fearful		
Fearfulness	1	2	3	4	5	6	7	8	9	10

Please complete and return this form at our first meeting. Please bring copies of any previous evaluations, progress reports, or IEP's at that time. Thank you for your cooperation with this questionnaire.

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Treatment and Observation Release Form

_____
Name of client

_____
Name of parent/guardian

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

☐ I do not give permission to Speech Journey to observe and/or videotape my child or 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 child's pediatrician or other medical professionals so that we can educate and inform your child's doctor about stuttering treatment and about the specifics of your child's case.*

1. _____

_____

2. _____

_____

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

1. _____

_____

2. _____

_____

_____ _____
Signature of Parent/Caregiver Date

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Client Confidentiality and Privacy Policies and Procedures

POLICY: All clients have a right to privacy. Confidentiality of clinical information will be maintained at all times during treatment and after the client is discharged from treatment. All clients have these rights under the Health Insurance Portability & Accountability Act of 1996 (HIPPA).

PROCEDURES:

1. Clinical information is kept in a private location, without public access.

2. The speech pathologist, her graduate assistants and office personnel are the only persons with access to clinical records.

3. Clinical information is kept out of view to a casual observer.

4. Clinical reports are released to third parties only with written consent of the client. In the case of a minor, written consent is obtained from a parent or legal guardian.

5. Clinical information is shared with other professionals by phone only with consent of the client. In the case of a minor, consent for phone contact with outside professionals is obtained from a parent or legal guardian.

6. At no time are clients discussed with outside parties without written consent of the client. In the case of a minor, written consent is obtained from a parent or legal guardian.

7. In cases where photography or videotaping is used, written permission to photograph or videotape is obtained from the client. In the case of a minor, written consent for phone contact with outside professionals is obtained from a parent or legal guardian.

8. Computer files containing clinical information are kept in one of two places:

   A. Clinical computer files are stored on the main computer by speech pathologist, graduate assistants and office personnel. Access to the computer is protected by a password. No identifying information of the patient is stored on graduate assistant files
   B. In cases where reports are written at a location other than the speech therapy office, files are stored on a disk, which is kept on the person of the speech pathologist and/or graduate assistant. No identifying information is stored on graduate assistant files

9. Client records are not faxed to another location without written permission from the client. In the case of a minor, written consent is obtained from a parent or legal guardian.

10. A copy of these policies and procedures will be shared with clients at the time of admission or at any time that changes are made to the policy.

I have read and understand the client confidentiality and privacy policies and procedures for Elena Caffentzis M.S. CCC-SLP. I understand that these will be explained to me if I have any questions.

Client name: _____

Signature of Client or Parent/Guardian: _____

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: _____