Starbuck Fluency Clinic
State University of New York at Geneseo

Adolescent/Adult Program
Case History Information Form

Please fill out the form below and send it to Dr. Kathleen R. Jones, Starbuck Fluency Clinic, State University of New York, 1 College Circle, Geneseo, NY 14454. All the information you provide will be confidential.

Name: _____ **Date:** _____

Date of Birth: _____ **Phone:** _____

Address: _____

Referred by: _____ **S.S. #** _____

Fill in whichever are applicable:

Parents: _____ **Spouse:** _____

Children & Ages: _____

Siblings & Ages: _____

Educational Status: _____

Vocational Goals: _____

Employment Status: _____

Interests/Leisure Activities: _____

_____

Medical Problems (including vision, hearing, allergies):

Medications taken daily:

Other communication difficulties:

Describe your stuttering (i.e., what happens when you stutter:)

Are you able to anticipate your stuttering? Yes____ No____
If so, please explain.

Do you do anything to "get your speech going" such as trying to control your breath, moving your head, tapping your foot, changing words, etc? Describe:

Place an X on the line below to rate the degree of your stuttering problem.

_____
Mild Moderate Severe

Lately, has your stuttering gotten worse_____ better_____?

What has led you to seek help for your stuttering at this time?

Have you received therapy for your stuttering before? If yes, please note where and when.

What were you taught to do?

What do people in your environment tell you to do ?

Are you able to use targets or controls that will ordinarily improve your speech fluency? No____ Yes____

If so, would you please describe those targets or controls.

Have you received any therapy other than speech (e.g., counseling, physical therapy, relaxation, etc.)?

How do others (family and friends) view your stuttering?

How does your stuttering impact on your daily home/social school/work life?

Are some situations/people harder for you?

Has stuttering influenced important choices/goals in your life up to this point?

Do you tend to avoid certain situations because of your stuttering?

Yes____ No____ Explain:

Is there a history of stuttering in your family? If yes, please note who else in your family does/did stutter.

What do you think caused your stuttering? Does your family have any different explanations?

What are the most important <u>results</u> you hope to receive from this therapy? Be as specific as you can about your expectations.