



Stuttering Center of Western Pennsylvania

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www.StutteringCenter.org

Diagnostic Intake Form For Teens Who Stutter

Part I: PERSONAL INFORMATION

Name: _____

Check one: Male Female

Date of Birth: _____

Age: _____

Home Address: _____

Home Phone: _____

Grade / School: _____

Parents' Names: _____

Work Phone: _____

Siblings:

1. _____

Age: _____

2. _____

Age: _____

Part II: HISTORY OF SPEECH/LANGUAGE PROBLEMS

1. Please describe your speaking difficulty in your own words: _____

2. How long have you had this speaking difficulty? _____

3. How has the problem changed since it first began? _____

4. Have you previously been assessed for speech/language concerns? Yes No
If so, please describe: _____

5. Have you previously received any speech/language therapy? Yes No
If so, where? _____ By whom? _____
For how long? _____ Focus of Treatment: _____
Results of Treatment: _____

6. Have any other family members had speech/language problems?
Yes No
Please indicate the person's relationship to you and the nature of the problem. _____

7. How does stuttering affect your:
Ability to participate in school activities? _____
Ability to participate in social activities? _____
Ability to interact with family members? _____
Ability to interact with friends? _____
Willingness to talk and communicate? _____
Self-esteem or attitude toward self? _____

8. In what situations do you experience the greatest difficulty? _____

9. In what situations do you experience the least difficult? _____

10. What factors seem to affect your fluency the most? _____

11. What else do you think we should know about you or your stuttering? _____

12. If you or your parents would like to receive the Stuttering Center's e-Newsletter, provide
your email address: teen: _____ parent: _____