



Fluency Case History Attachment

Name: _____

Description of problem: Check all that apply: Repetitions of sounds words phrases
 Prolonged sounds Silent pause/block in speech
Are there particular sounds or words that are difficult? _____

Onset of stuttering _____ **Circle one:** Gradual or Sudden
(Date)

Did it follow any illness/family problem/traumatic event? No Yes (describe): _____

How long have you been stuttering? _____

Has it changed over time? _____

Is the problem: consistent intermittent

Can you anticipate stuttering? No Yes

Do you do anything to control your stuttering? _____

When is your speech the best/worst? _____

What bothers you most about your stuttering? _____

Please describe any situations you avoid because you stutter: _____

Family and Social History

How does your stuttering affect your school/work? _____

Is there a history of stuttering in your family? _____

Do relatives and others say negative things about your stuttering? _____

Previous Therapy History

Have you received previous therapy? No Yes

When: (Date) _____ By whom? _____

Why was therapy discontinued? _____

What helped your speech the most? _____

Are there any techniques you still use? _____

What are your expectations for therapy at this time? _____

Please write down any additional information you feel will help us to understand your stuttering? _____