Adult/Teen Application Form
- for applicants 12 years of age and over -

Name: ___________________________________________  Birthdate: ____________________________
(day/month/year)

Sex:   F  M

Address: __________________________________________

City: _____________________________ Province: _________________ Postal Code: __________

Phone (home): ____________________________ (work): ____________________________
(include area code) (include area code)

Preferred Contact Method: _____________________ E-mail address: __________________________

How did you hear about us? ________________________________

_____________________________________________________________________________________

TEENAGED APPLICANTS (12-17 years) - complete sections I and III below
ADULT APPLICANTS (18 & older) - complete sections II and III below

SECTION I - (Teenagers complete this section)

PARENTS OR GUARDIANS

Relationship to child, if Guardian: __________________________________________

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<th>Mother</th>
<th>Father</th>
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<td>Address: (if different from above)</td>
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FAMILY AND SCHOOL

Names and ages of brothers and sisters: ____________________________________________________________

Twin sister: ☐ Twin brother: ☐ Identical: ☐ Fraternal: ☐
Twin brother or sister stutters: Yes ☐ No ☐
School you attend: ___________________________________________ Grade: ______________
Overall school performance: Good ☐ Fair ☐ Poor ☐
Extracurricular activities, hobbies: ____________________________________________________________

Hand preference: Left ☐ Right ☐ Preference has switched ☐

SECTION II - (Adults complete this section)

Place of employment: ________________________________________________________________
Type of employment: ________________________________________________________________
Level of schooling last completed: __________________________________ Date: ________________
Marital status: Single ☐ Married ☐ Divorced ☐ Separated ☐
Name of spouse: ________________________________________________________________
Names of children: ___________________________________________________________________

Special interests: ___________________________________________________________________

Twin sister: ☐ Twin brother: ☐ Identical: ☐ Fraternal: ☐
Twin brother or sister stutters: Yes ☐ No ☐
Hand preference: Left ☐ Right ☐ Preference has switched ☐

SECTION III - (Both adults and teenagers complete this section)

MEDICAL

Family Physician: ________________________________________________________________
Address: ________________________________________________________________________
Hospitalizations:  No ☐  Yes ☐  Place: ____________________________
  Reasons for hospitalization: ____________________________
  In what years: ____________________________
Medical or psychiatric problems for which you have received or are now receiving treatment: ________

Medication you are taking: ____________________________
  Reason: ____________________________

LANGUAGE BACKGROUND
Mother tongue: ____________________________
Other languages spoken: ____________________________
  Learned: (places): ____________________________
    (dates): ____________________________

SPEECH HISTORY
Age at which stuttering first began: _____________ (in years and months)
Presumed cause of stuttering: ____________________________
Stuttering first noticed by: ____________________________
Relatives, close or distant, who stutter: ____________________________

Reaction of family and friends to your stuttering: ____________________________

How has your stuttering changed: ____________________________
Situations in which your stuttering worsens: ____________________________

Sounds which you find especially difficult: ____________________________
Words or situations you avoid: ____________________________

Your classification of your stuttering: (select appropriate number)

1 ☐  2 ☐  3 ☐  4 ☐  5 ☐  6 ☐  7 ☐  8 ☐
mild  moderate  severe  very severe
Ways in which stuttering handicaps you:


Previous therapy for stuttering, if any:

Place: ____________________________

Date and duration: ____________________________

Type of procedure used: ____________________________

Results: ____________________________

Additional comments that may help us understand your stuttering:


APPLICATION FOR:

- Assessment only
- Assessment and therapy

- I may be interested in an intensive clinic (specify which clinic) ____________________________

- I prefer to be assessed in Calgary

- I prefer to be assessed in Edmonton

- I have no preference as to the Calgary or Edmonton office

- I prefer a long-distance assessment (phone or telehealth – videoconferencing). If you would like this assessment via telehealth please include the name and phone number of your local telehealth coordinator.

SIGNATURE OF APPLICANT: ____________________________ Date: ____________________________ (day/month/year)

(Signature of parent or guardian if applicant is under 18)

Please email completed form to: istor@ualberta.ca

Or fax it to: (780) 492-8457

Or send it to: ISTAR
Suite 1500, College Plaza
8215 – 112 Street
Edmonton, Alberta, Canada T6G 2C8

Applying for treatment shows your consent to being contacted occasionally via email about current course offerings (refreshers or workshops, etc), and occasional paid programs and events. As always, you can unsubscribe from a particular email mailing list at any time by clicking the unsubscribe link on those emails.

Protection of Privacy - The personal information requested on this form is collected under the authority of Section 33 (c) of the Alberta Freedom of Information and Protection of Privacy Act and will be protected under Part 2 of that Act. It will be used in a confidential manner, for the purpose of delivering speech therapy services and for providing updates and information about ISTAR. Direct any questions about this collection to: ISTAR, Suite 1500 College Plaza, 8215 – 112 Street, Edmonton, Alberta, T6G 2C8. Phone: 780-492-2619. Email: istor@ualberta.ca