



Communication Improvement Program
Institute for Stuttering Treatment and Research
An Institute of the Faculty of Rehabilitation Medicine, University of Alberta

CHILD APPLICATION FORM

Name: _____ Birthdate: _____
(day/month/year)

Sex: F M Age: _____ *(in years and months)*

Address: _____

City: _____ Province: _____ Postal Code: _____

Primary Phone: _____ Preferred Contact Method: _____
(include area code)

Family Physician: _____

Address: _____ Postal Code: _____

Child's School: _____

Present Grade: _____ Teacher: _____

How did you hear about us? _____

PARENTS OR GUARDIANS

Relationship to child, if Guardian: _____

	<u>Mother</u>	<u>Father</u>
Name:	_____	_____
Address (if different: than above)	_____	_____
Occupation:	_____	_____
Phone (home):	_____	_____
(work):	_____	_____
(cell):	_____	_____
Fax:	_____	_____
E-mail:	_____	_____

BIRTH HISTORY

Mother's general health during pregnancy (illnesses, accidents, medications, alcohol or drug exposure?)

Duration of pregnancy: _____ Child's birth weight: _____

Were there any other unusual conditions that may have affected the pregnancy or birth?

HEALTH

Is there a family history of any of the following? Please circle Yes or No and if yes, indicate relationship to child (i.e., mother, father, grandparent, sister, brother etc.)

For example,

Hearing Loss	NO <input checked="" type="radio"/> YES- <i>Father</i>
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Hearing loss	NO YES-	Prematurity	NO YES-
Speech Delay/Disorder	NO YES-	Vision Loss/ Impairment	NO YES-
Language Delay/Disorder	NO YES-	Mental Illness	NO YES-
Alcohol or Drug Exposure during pregnancy	NO YES-	Academic difficulties	NO YES-
Motor skill delay or disorder	NO YES-	Feeding or Swallowing difficulties	NO YES-
Physical/Medical Concerns	NO YES-	Other?	NO YES-

Has your child's hearing been tested? If yes, what were the results? If no, do you have concerns regarding their hearing: _____

Has your child's vision been tested? If yes, what were the results? If no, do you have concerns regarding their vision: _____

Child is on medication? No _____ Yes _____ Type: _____

Reason for medication: _____

DEVELOPMENTAL HISTORY

Age at which child first sat alone _____; crawled _____; stood alone _____;
 walked _____; controlled bladder _____; controlled bowel _____.

Hand preference: left ____; right ____; both ____.

Has your child changed hand preference? Yes ____ No ____

General coordination: _____

My child runs ____; catches ball ____; jumps ____; falls frequently ____.

Has your child had any feeding difficulties? Check each item that applies.

- ____ Sucking or nursing
 ____ Long time to drink bottle
 ____ Food or drink out through the nose
 ____ Difficulty chewing or swallowing meats
 ____ Choking and/or gagging

Does your child currently choke or cough while eating? Yes ____ No ____

If "yes," on what foods? _____

Does your child drool more than other children his/her age? Yes ____ No ____

SPEECH AND LANGUAGE

Did your child babble during early months? Yes ____ No ____

Child cried? Rarely ____ A little ____ A lot ____ Constantly ____

Language most often spoken by child: _____

Other languages spoken by child: _____

Age at which child said first word: _____

first joined two words (e.g. "more juice") _____

first used sentences (e.g. "I want milk") _____

first asked simple questions (e.g., "Where's doggie?")

How does your child let you know what s/he wants?

- ____ looking at objects ____ pointing at objects ____ gestures
 ____ crying ____ makes sounds/ grunting ____ physical manipulation (i.e., takes you by the hand)
 ____ single words ____ 2-3 word combinations ____ sentences

Which of the following do you think your child understands?

- ____ his/her own name ____ names of body parts ____ family names
 ____ names of objects ____ simple directions ____ complex directions (e.g., doing three things in the
 order you tell him/her to) ____ conversational speech
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Which of the following best describes your child's speech?

- I can understand him/her easily
- I have trouble understanding him/her
- Other people have trouble understanding him/her
- Other people can almost never understand what he/she says
- His/her speech is different from other children his/her age

Does your child have difficulty producing certain sounds? Yes No

If "yes," which ones? _____

Does your child hesitate and/or repeat sounds or words? Yes No

Does your child "get stuck" when attempting to say a word? Yes No

If "yes," please describe _____

Do you have concerns about your child's voice? Yes No

If "yes," please describe _____

Please describe your concerns about your child's speech, language and/or communication skills: _____

When were these concerns first noticed? By whom? _____

Is your child aware of these difficulties? If yes, how do they feel about it? _____

Child's previous treatment for speech, language, communication concerns, if any:

Place: _____

Date and duration: _____

Type of procedures used: _____

Results: _____

Treatment your child has received for other conditions: _____

EDUCATIONSchool performance: *(circle appropriate description)*

In general:	good	fair	poor	Reading:	good	fair	poor
Spelling:	good	fair	poor	Math:	good	fair	poor

Does your child receive special services or support at school? If yes, please describe: _____

Is your child frequently absent from school? If yes, please explain: _____

Outside activities: _____

FAMILY AND SOCIAL LIFE

Others living in the home:

Name	Age	Relationship	Name	Age	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Child's personality while at home (excitable, depressed, shy, happy, easy to manage, negative, easy to get along with, etc.):

Playmates: No _____ Yes _____ Ages _____

Child gets along with playmate: *(circle one)* well / so-so / poorly

Favorite activities: _____

What is the average length of time your child can stay playing at one activity? _____

Do you have concerns about your child's ability to focus or pay attention? Has your child's teacher expressed concerns about their ability to focus? If yes, please describe

OTHER AGENCIES

Have any other specialists (e.g., speech-language pathologists, doctors, psychologists, audiologists etc.) seen your child? Who and when? Please attach their notes or reports.

Agencies	Address	Date seen

Additional comments that may help us understand your child and his/her challenges:

What are you hoping that your child will gain from speech-language treatment?

Please indicate if you are planning on accessing Early Childhood Services Funding to support ISTAR treatment costs Yes No

APPLICATION FOR: Assessment only Assessment and therapy

- 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 PARENT OR GUARDIAN: _____ (Date)

Please send completed form to: Institute for Stuttering Treatment and Research
Suite 1500, College Plaza, 8215 – 112 Street
Edmonton, Alberta T6G 2C8

Or fax it to: (780) 492-8457

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: istar@ualberta.ca