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 ❑ Another/prefer not to disclose ❑ 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: ____

		Mother	Father
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 (YES-) *Father*

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

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: ____________________________
____
____

EDUCATION

School 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

SIGNATURE OF PARENT OR GUARDIAN: ___

(Date)

Please send completed form to: Institute for Stuttering Treatment and Research
8205 114 St, 3-48 Corbett Hall
Edmonton, AB Canada T6G 2G4

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, 8205 114 St, 3-48 Corbett Hall, Edmonton, AB Canada T6G 2G4 Phone: (780) 492-2619. Email: **istar@ualberta.ca**