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

Child Application Form

- To be completed by parents of children 11 years and younger -

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

Child's Gender Identity: _____
(e.g., female, male, nonbinary, two-spirit, prefer not to disclose) Age: _____ *(years; 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: _____

		Parent/Guardian	Parent/Guardian
Name:		_____	_____
Address (if different than above)		_____	_____
		_____	_____
Occupation:		_____	_____
Phone	(home):	_____	_____
	(work):	_____	_____
	(cell):	_____	_____
Fax:		_____	_____
E-mail:		_____	_____

BIRTH HISTORY

During this pregnancy, did the mother experience any unusual illness or condition (e.g. German Measles, Rh incompatibility, false labour, etc)?

No ❑ Yes ❑

If yes, please describe: _____

_____

Duration of pregnancy: _____ Unusual occurrences: _____

_____

Child's birth weight: _____ Evidence of birth injury: _____

HEALTH

General health of child during early years: _____

Problem	Age	Fever	Length of Illness	After-effects

Convulsions? No ❑ Yes ❑ Type and frequency: _____

_____

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

_____

Reason for medication: _____

Other: (check where appropriate)

Hearing difficulties ❑ Vision difficulties ❑ Wears glasses ❑

Difficulty breathing/breathing through mouth ❑ Physical/motoric differences ❑

Other (please specify): _____

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: _____

The child runs ❑ skates ❑ catches ball ❑ jumps ❑ falls frequently ❑

SPEECH AND LANGUAGE

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

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

Language(s) most often spoken at home: _____

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") _____

Child's stuttering was first noticed by: _____

Child's age when he/she began stuttering: _____ *(in years and months)*

What do you think caused your child's stuttering? _____

_____

_____

Stuttering varies? No ❑ Yes ❑ Has changed *(describe)*: _____

_____

_____

Does your child stutter when: talking while playing alone ❑ singing ❑

Things that improve your child's speech: _____

_____

_____

Sounds that give your child special difficulty: _____

_____

_____

Words or situations your child avoids: _____

_____

_____

Other speech or language difficulties experienced by child: _____

_____

_____

Concerns about your child other than stuttering: _____

_____

_____

Child's stuttering is (*select appropriate number*)

0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑

no stuttering — mild — moderate — most severe stuttering you can imagine

Child's relatives, close or distant, who stutter: _____

_____

Ways in which stuttering affects child: _____

_____

_____

Child's previous therapy for stuttering, if any:

Place: _____

Date and duration: _____

Type of procedures used: _____

Results: _____

Other therapy, if any:

_____

_____

EDUCATION

School performance: (*select appropriate description*)

In general: good ❑ fair ❑ poor ❑ Reading: good ❑ fair ❑ poor ❑

Spelling: good ❑ fair ❑ poor ❑ Math: good ❑ fair ❑ poor ❑

Extracurricular activities: _____

_____

FAMILY AND SOCIAL LIFE

Others living in the home:

Name	Age	Relationship	Name	Age	Relationship

Twin sister ❑ Twin brother ❑ Identical ❑ Fraternal ❑

Twin brother or sister stutters: Yes ❑ No ❑

How would you describe your child's personality? (e.g., outgoing, excitable, happy, shy, sensitive, becomes emotional easily, curious, anxious, always on the move, etc.)

_____

_____

_____

Playmates: No ❑ Yes ❑ Ages _____

Child gets along with them: (*select one*) well ❑ so-so ❑ poorly ❑

Favorite activities: _____

_____

OTHER AGENCIES

Other agencies such as clinics, special schools that your child has attended for treatment:

Agencies	Address	Date seen

Additional comments that may help us understand your child and their stuttering:

_____

_____

_____

APPLICATION FOR: ❑ Assessment only ❑ Assessment and therapy

❑ I prefer to be assessed virtually through video-conferencing (e.g., Zoom/Google Meet)

❑ If possible, I prefer to be assesssed in person:

❑ in Calgary ❑ in Edmonton ❑ no preference

For school-age children aged 7-11: Are you interested in the summer intensive program for children?

❑ Yes ❑ No ❑ Not Sure

SIGNATURE OF PARENT OR GUARDIAN: _____ _____
(Date)

Please email completed form to: istar@ualberta.ca

Or fax it to: (780) 492-8457

Or send it to: ISTAR
8205 114 St, 3-48 Corbett Hall
Edmonton, AB Canada T6G 2G4

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