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