South Lakes Speech & Language Therapy
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Fluency Questionnaire

Child: _____ **Date of Birth:** _____

Person completing this form: _____

Is there a family history of stuttering or recovering from stuttering? Yes / No

If yes, please give details _____

_____

At what age did your child start stuttering? _____

How has your child's stuttering changed (if at all) since it started? _____

_____

Has your child ever been teased about stuttering? Yes / No

If yes, please give details _____

_____

Has your child ever talked with you about his / her stuttering? Yes / No

If yes, please give details _____

_____

Are there situations where your child stutters less? Yes / No

If yes, please give details _____

_____

How do you respond when your child stutters? _____

_____

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How do other family members and close friends respond when your child stutters? _____

_____

_____

Has your child ever demonstrated any of the following:

- Awareness of stuttering
- Frustrating about speaking
- Physical tension while stuttering
- Complaints about not being able to talk

Please explain / describe: _____

_____

How often do the following behaviours occur?
Please circle one per item (O = often, S = sometimes, N = Never)

• Inattentiveness	O	S	N
• Hyperactivity	O	S	N
• Nervousness	O	S	N
• Sensitivity	O	S	N
• Perfectionism	O	S	N
• Excitability	O	S	N
• Frustration	O	S	N
• Strong Fears	O	S	N
• Excessive Neatness	O	S	N
• Excessive Shyness	O	S	N
• Lack of Confidence	O	S	N
• Competitiveness	O	S	N

How would you describe your child's overall temperament? _____

_____

_____

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Which of the following stuttering behaviours do you see / hear your child demonstrate?

- Repeating short phrases (e.g., “I want, I want, I want juice.”).
- Repeating whole words (e.g., “Can, can, can I have some?”).
- Starting to talk then revising what they say (e.g., “My dad, my mom, my family went to the park.”).
- Repeating the initial sound of words (e.g., “S-S-Sing a song.”).
- Prolonging or stretching out sounds (e.g., “Mmmmmmy car”).
- Blocking on sounds (e.g. “--------I like ice cream.”).
- Using extra words or fillers (e.g., um, uh, like).

Rate how often your child is able to speak fluently (without stuttering) in the following situations (circle one per column):

At Home	**At School**	**In New Situations**
Always	Always	Always
Almost Always	Almost Always	Almost Always
Sometimes	Sometimes	Sometimes
Rarely	Rarely	Rarely
Never	Never	Never

Rate how often your child is able to speak without his/her stuttering affecting overall communication (i.e. when your child does stutter, they are still able to communicate their message clearly) (circle one per column):

At Home	**At School**	**In New Situations**
Always	Always	Always
Almost Always	Almost Always	Almost Always
Sometimes	Sometimes	Sometimes
Rarely	Rarely	Rarely
Never	Never	Never

Has your child’s teacher noticed your child’s stuttering? _____

_____

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How does your child's stuttering affect his / her…

- Participation at school? _____
- Academic performance? _____
- Interaction with other children? _____
- Interaction with family members? _____
- Willingness to talk and communicate? _____
- Self-esteem or attitude toward self? _____

Is there anything else you would like to tell me about your child's stuttering? _____

_____

_____

_____

_____

Please return this form prior to your initial appointment, thank you.
* NB I will not make contact with other professionals without your permission.