

**Northwest Center for Fluency Disorders Interprofessional Intensive Stuttering Clinic (NWCFD-IISC)**

**Idaho State University Departments of Communication Sciences & Disorders and Counseling**

*(Clinic dates: July 30th – August 13th, 2016; typically 9am – 5pm daily.)*

Date application was completed: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Name of person completing application if other than client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client *(if appropriate)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has client been seen in our clinic before?  Yes  No

If “yes,” when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why is client applying for services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT & GUARDIAN INFORMATION**

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate:\_\_\_/\_\_\_\_/\_\_\_\_\_\_  Male  Female

Guardian Name *(if appropriate):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City, State, Zip): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Phone: Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

T-shirt size: (Adult S, M, L, XL, XXL) Style: Male\_\_\_\_\_\_\_ Female\_\_\_\_\_\_\_

**Medical**

Please list any allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medical conditions that we should know about:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications that we should know about:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*IN CASE OF EMERGENCY*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Family Members / Caregivers** | **“X” if Legal Guardian(s)** | **Relationship (e.g., mother, father,**  **husband, wife, sister, son etc)** | **Phone Number** | **“X” if lives with you** |
|  |  |  |  |  |
|  |  |  |  |  |

**REFERRAL INFORMATION**

How did you hear about our clinic?

Professional Referral:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

From where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Website Phone Book Friend

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY OF SPEECH, LANGUAGE, VOICE, HEARING, COGNITION, and AFFECTIVE**

Do you have a history of speech, language, hearing, or cognitive difficulties from birth to present? Yes No Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**EDUCATIONAL HISTORY:**

Schools you have attended – Please check all that apply:

Elementary School Junior High  High School Vocational Program

2-year College 4-year College Graduate School Doctoral Program

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past or Current School/University:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade/Status:\_\_\_\_\_\_\_\_

Major:\_\_\_\_\_\_\_\_\_\_\_ Degree(s):\_\_\_\_\_\_\_\_\_\_\_\_ Teacher (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VOCATIONAL HISTORY**

Briefly list your employment/work setting, staring with the most recent:

|  |  |
| --- | --- |
| **Job Title** | **Years Worked** |
|  |  |
|  |  |
|  |  |

Are you currently working?  Yes  No

If “no,” please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have stopped working, do you plan to return to work? Yes No

Are you receiving assistance with vocational planning through an agency such as the Department of Vocational Rehabilitation?  Yes  No

**CURRENT SERVICES:** Do you currently receive Speech Therapy Services? Yes No If yes, where “please list all” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Speech Language Pathologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Should we contact them regarding how we approached therapy?

Yes  No (if yes, Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Please list any previous speech-language evaluation and/or therapy (e.g., school, clinic, hospital, home health)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Services** | **When** | **Where** | **What was not helpful** | **What was helpful** |
|  |  |  |  |  |
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|  |  |  |  |  |

*\*If you have access to them, please send copies with this application of any reports of evaluations and/or treatment that you have received.*

**COMMUNICATION**

Current Activities and Interests - Please check the appropriate box(s)

Socializing  Church  Sports  Watching T.V.  Reading

Senior Center  Exercising  Music  Gardening  Shopping  Woodworking  Crafts  Being Outdoors  Painting/Art  Book Club Photography  Pets  Computers  Travel  Cooking  Board Games  Casinos Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIFE IMPACT**

On a scale of 1-10, with 1 being “not at all” and 10 being “devastating,” please rate how your communication disorder impacts your daily life:

*Not At All* 1 2 3 4 5 6 7 8 9 10 *Devastating*

How would you rate the severity of your stuttering?

Very Mild Mild-Moderate Moderate Moderate-Severe Severe

**PAYMENT INFORMATION**

* The NWCFD-IISC fee is $1500, which covers the program fees, housing, food, participation in the challenge course, and other clinic-related expenses *(does not include travel to or from the clinic)*.
  + Scholarships available (please visit [www.northwestfluency.org](http://www.northwestfluency.org) or e-mail Dan Hudock [hudock@isu.edu](mailto:hudock@isu.edu))
* A $200 deposit is required for clients to reserve their space (as we have limited availability).
* The balance of $1300 is due by the third day of clinic.
* Please contact the ISU Speech-Language and Hearing Clinic (Jessica Hillam (208) 282-3495 or slpaudio@isu.edu for information about E-Payments through our online system).
* Please fax registration to the ISU Speech-Language and Hearing Clinic (208) 282-4571, or mail / drop it off
  + Pocatello Clinic – ISU Speech and Hearing Clinic Pocatello, 650 Memorial Dr. building 68, Pocatello, ID 83201