

**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

*\*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)
* 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