



Northwest Center for Fluency Disorders Interprofessional Intensive Stuttering Clinic (NWCDF-IISC)
Idaho State University Departments of Communication Sciences & Disorders, Counseling and Psychology

(Clinic dates: July 14th – 28th, 2018; 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 _____ (They run small in female cuts)

Medical

Please list any allergies: _____
 Please list any medical conditions that we should know about: _____
 Please list any medications that we should know about: _____
 Please list any mental health diagnoses 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: _____ Highest grade completed: _____

Major: _____ Degree(s): _____

Are/were you on an individualized education plan (IEP)? Please provide a copy if you have one.

VOCATIONAL HISTORY

Briefly list your employment/work setting, starting 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 any mental health services? Yes No If yes, where “please list all”

Primary Therapist: _____

Would you like us to contact them prior to you attending the clinic?

Yes No (if yes, Phone: _____)

**If you would like us to communicate with them after the clinic please indicate that on the mutual exchange of information for during the clinic.*

Would you be willing to seek counseling services in the future? ? Yes Maybe No

Do you currently receive Speech Therapy Services? Yes No If yes, where “please list all”

Primary Speech Language Pathologist: _____

Would you like us to contact them prior to you attending the clinic?

Yes No (if yes, Phone: _____)

**If you would like us to communicate with them after the clinic please indicate that on the mutual exchange of information for during the clinic.*

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

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)

- | | | | | |
|--|-------------------------------------|---|--|------------------------------------|
| <input type="checkbox"/> Socializing | <input type="checkbox"/> Church | <input type="checkbox"/> Sports | <input type="checkbox"/> Watching T.V. | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Senior Center | <input type="checkbox"/> Exercising | <input type="checkbox"/> Music | <input type="checkbox"/> Gardening | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Woodworking | <input type="checkbox"/> Crafts | <input type="checkbox"/> Being Outdoors | <input type="checkbox"/> Painting/Art | <input type="checkbox"/> Book Club |
| <input type="checkbox"/> Photography | <input type="checkbox"/> Pets | <input type="checkbox"/> Computers | <input type="checkbox"/> Travel | <input type="checkbox"/> Cooking |
| <input type="checkbox"/> Board Games | <input type="checkbox"/> Casinos | <input type="checkbox"/> Other: _____ | | |

What speaking situations are easier for you?

What speaking situations are harder for you?

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

PRIOR KNOWLEDGE

What strategies do you use when communicating?

What currently helps you in difficult speaking situations?

GOALS AND EXPECTATIONS

Please list any goals and expectations for the IISC. What would you like to learn?

PAYMENT INFORMATION

- The cost of the clinic is \$1,000, which *covers lodging, most meals (\$150 ISU food card that can be used at the cafeteria), participation in the ropes course, t-shirt, and clinic-related materials and expenses over the two weeks.*
 - Some scholarships are available (please visit www.northwestfluency.org or e-mail Dan Hudock hudock@isu.edu)
- A \$200 deposit for lodging is required for clients to reserve their space (as we have limited availability).
- The remaining balance will be due by the end of the first Tuesday of the clinic.
- Please contact the ISU Speech-Language and Hearing Clinic (Beca Sidell (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