

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

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

*(Clinic dates: July 27th – August 8th, 2020; 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

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*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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest grade competed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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, 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 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** |
|  |  |  |  |  |
|  |  |  |  |  |
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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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What speaking situations are easier for you?

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

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What speaking situations are harder for you?

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

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**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?

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

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What currently helps you in difficult speaking situations?

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**GOALS AND EXPECTATIONS**

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

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**PAYMENT INFORMATION**

* The cost of the clinic is $1,500, 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](http://www.northwestfluency.org) or e-mail Dan Hudock [hudock@isu.edu](mailto: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