Child Application Form
- To be completed by parents of children 11 years and younger -

Name: _______________________________________________ Birthdate: ____________________________ (day/month/year)

Child’s Gender Identity: ____________________________________ (e.g., female, male, nonbinary, two-spirit, prefer not to disclose) Age: ________ (years; months)

Address: ____________________________________________

City: ___________________________ Province: _______________ Postal Code: ______________

Primary Phone: ___________________________ Preferred Contact Method: _____________________

(include area code)

Family Physician: __________________________________________

Address: _______________________________________________ Postal Code: ______________

Child’s School: __________________________________________

Present Grade: _______________ Teacher: _______________

How did you hear about us? ______________________________________

**PARENTS OR GUARDIANS**

Relationship to child, if Guardian: __________________________

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<th>Parent/Guardian</th>
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<td>Name:</td>
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<td>Address (if different: than above)</td>
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<td>Occupation:</td>
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**BIRTH HISTORY**

During this pregnancy, did the mother experience any unusual illness or condition (e.g. German Measles, Rh incompatibility, false labour, etc)?

- No □  Yes □

If yes, please describe: ____________________________  
______________________________

Duration of pregnancy: ________________  Unusual occurrences: ________________  
______________________________

Child’s birth weight: ________________  Evidence of birth injury: ________________

**HEALTH**

General health of child during early years: ____________________________

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<tr>
<th>Problem</th>
<th>Age</th>
<th>Fever</th>
<th>Length of Illness</th>
<th>After-effects</th>
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Convulsions?  No □  Yes □  Type and frequency: ____________________________

Child is on medication?  No □  Yes □  Type: ____________________________

Reason for medication: ____________________________

Other: (check where appropriate)

- Hearing difficulties □
- Vision difficulties □
- Wears glasses □
- Difficulty breathing/breathing through mouth □
- Physical/motoric differences □
- Other (please specify): ____________________________

**DEVELOPMENTAL HISTORY**

Age at which child first sat alone ______; crawled ______; stood alone ______;  
walked ______; controlled bladder ______; controlled bowel ______.

Hand preference:  left □  right □  both □

Has your child changed hand preference?  Yes □  No □

General coordination: ____________________________

The child runs □  skates □  catches ball □  jumps □  falls frequently □
**SPEECH AND LANGUAGE**

Did your child babble during early months?  Yes ☐  No ☐

Child cried?  Rarely ☐  A little ☐  A lot ☐  Constantly ☐

Language(s) most often spoken at home: ____________________________________________

Other languages spoken by child: _________________________________________________

Age at which child said first word: __________

  first joined two words (e.g. “more juice”) __________

  first used sentences (e.g. “I want milk”) __________

Child’s stuttering was first noticed by: ____________________________________________

Child’s age when he/she began stuttering: _______________ (in years and months)

What do you think caused your child’s stuttering? __________________________________

_____________________________________________________________________________

Stuttering varies?  No ☐  Yes ☐  Has changed (describe): ___________________________

_____________________________________________________________________________

Does your child stutter when: talking while playing alone ☐  singing ☐

Things that improve your child’s speech: _________________________________________

_____________________________________________________________________________

Sounds that give your child special difficulty: _________________________________

_____________________________________________________________________________

Words or situations your child avoids: ___________________________________________ 

_____________________________________________________________________________

Other speech or language difficulties experienced by child: _________________________ 

_____________________________________________________________________________

Concerns about your child other than stuttering: _________________________________ 

_____________________________________________________________________________

Child’s stuttering is (select appropriate number)

0 ☐  1 ☐  2 ☐  3 ☐  4 ☐  5 ☐  6 ☐  7 ☐  8 ☐  9 ☐

no stuttering  mild  moderate  most severe stuttering you can imagine
Child’s relatives, close or distant, who stutter: __________________________________________

Ways in which stuttering affects child: ______________________________________________

___________________________________________________________

Child’s previous therapy for stuttering, if any:
  Place: _________________________________________________________
  Date and duration: _____________________________________________
  Type of procedures used: _______________________________________
  Results: ______________________________________________________

Other therapy, if any:
____________________________________________________________________

EDUCATION

School performance: (select appropriate description)
  In general: good □  fair □  poor □  Reading:  good □  fair □  poor □
  Spelling:  good □  fair □  poor □  Math:  good □  fair □  poor □
  Extracurricular activities: _______________________________________

FAMILY AND SOCIAL LIFE

Others living in the home:

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<th>Relationship</th>
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Twin sister □  Twin brother □  Identical □  Fraternal □

Twin brother or sister stutters: Yes □  No □

How would you describe your child’s personality? (e.g., outgoing, excitable, happy, shy, sensitive, becomes emotional easily, curious, anxious, always on the move, etc.)
____________________________________________________________________
____________________________________________________________________
Playmates:  No □    Yes □    Ages ____________________________

Child gets along with them: (select one)  well □    so-so □    poorly □

Favorite activities: _______________________________________________

OTHER AGENCIES

Other agencies such as clinics, special schools that your child has attended for treatment:

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<th>Agencies</th>
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Additional comments that may help us understand your child and their stuttering:

APPLICATION FOR:  □  Assessment only   □  Assessment and therapy

□  I prefer to be assessed virtually through video-conferencing (e.g., Zoom/Google Meet)

□  If possible, I prefer to be assessed in person:

□  in Calgary   □  in Edmonton   □  no preference

For school-age children aged 7-11:  Are you interested in the summer intensive program for children?

☐  Yes   ☐  No   ☐  Not Sure

SIGNATURE OF PARENT OR GUARDIAN: ____________________________  (Date)

Please email completed form to:  istar@ualberta.ca

Or fax it to:   (780) 492-8457

Or send it to: ISTAR

8205 114 St, 3-48 Corbett Hall

Edmonton, AB  Canada  T6G 2G4

Applying for treatment shows your consent to being contacted occasionally via email about current course offerings (refreshers or workshops, etc), and occasional paid programs and events. As always, you can unsubscribe from a particular email mailing list at any time by clicking the unsubscribe link on those emails.

Protection of Privacy - The personal information requested on this form is collected under the authority of Section 33 (c) of the Alberta Freedom of Information and Protection of Privacy Act and will be protected under Part 2 of that Act. It will be used in a confidential manner, for the purpose of delivering speech therapy services and for providing updates and information about ISTAR. Direct any questions about this collection to:  ISTAR, 8205 114 St, 3-48 Corbett Hall, Edmonton, AB  Canada  T6G 2G4. Phone: 780-492-2619. Email: istar@ualberta.ca