Midland CHILDREN'S rehabilitation center

802 Ventura Midland, TX 79705 PH: 432.498.2053 Fax: 432.682.4478 www.midlandchildrens.org

Dear Parent/caregiver,

Thank you for contacting us regarding therapy services for your child. Due to the demand for Physical (PT), Occupational (OT) and Speech Therapy (ST) in our area, we are currently managing a wait list for all three services. Please completely fill out the attached paperwork and return it to our facility *with a prescription for therapy from your physician*. The prescription must be discipline specific, preferably stating "evaluation and treatment" and should include a discipline specific diagnosis.

Once this paperwork is received, you will be placed on a waiting list for services. As appointments become available, we will call you to schedule an evaluation. At that time, you will receive an email with instructions on how to set up a Patient Dashboard and complete your child's medical history. This information must be complete prior to the initial evaluation. Please be sure to contact us if any information has changed. If we are unable to reach you, your child will be removed from the waiting list and will not receive an evaluation from Midland Children's Rehabilitation Center. In the event that you are seeking services for multiple disciplines, you will be scheduled for separate evaluations at different times.

Evaluations typically take one hour. If your child qualifies for therapy, we will contact you to set up your child's therapy schedule. Our hours of operation are Monday through Thursday from 8 am to 5:30 pm, and Friday from 8 am to 12 pm. There is no guarantee as to the availability of any specific appointment time.

The following items must be received before your child can be added to the waiting list:

- Consent Forms (pg. 1-7)
- Demographics and Therapy Goals (pg. 8-10)
- Prescription with a discipline specific diagnosis (OT, PT, ST) **"evaluation and treatment"**

Due to the nature of our waiting list, all paperwork listed above must be turned in at the same time. The front office will not accept any incomplete paperwork.

Please feel free to contact us at any time if you have questions. We look forward to meeting you and your child at the time of their evaluation.

Sincerely,

Candelaria Bejarano
Scheduling and Admissions Administrator

Midland CHILDREN'S rehabilitation center

MCRC Policies to Remember:

In case of **FOUL WEATHER:**

- MCRC will follow recommendations from MISD for center closure or delayed opening.
- A message will be placed on the Center answering machine explaining alternate hours of operation for the day based on the recommendation from MISD.

Regarding **PAYMENT**:

- There is no charge for the evaluation or therapy your child may receive at MCRC. We do NOT bill insurance. We DO NOT receive any state or federal funding.
- We are funded 100% through private donations, special events, corporate support and grants.
- Your support is needed! A monthly donation is one of the easiest ways to support MCRC. Please visit www.MidlandChildrens.org/donate to make a difference today.
- If you are unable to contribute financially, please consider donating an "item of the month" or even volunteering with us! We would love to have your help with mail-outs, events, etc.

In case of **CHILD ILLNESS:**

- Your child must be free of vomiting and diarrhea 24 hours **prior to their appointment**.
- Your child must be fever free for 24 hours **prior to their appointment** without the assistance of fever reducing medication.
- Therapists reserve the right to stop a therapy session if they believe your child is sick.
- Parents should use their best judgement regarding their child's ability to tolerate treatment sessions & the safety/well-being of other clients.
- Parents are responsible for notifying MCRC of cancellation prior to your appointment time.

Regarding **PRIVACY:**

- No personal photographs or videos are permitted during your visit to MCRC.
- If you wish to capture your child through video or pictures, please speak with your therapist.
- Parents must be invited to attend a therapy session. To protect the privacy of other clients, roaming the facility without authorization is not allowed.

Regarding **ATTENDANCE:**

- Consistent attendance is crucial for therapeutic benefit.
- If you are more than 15 minutes late to an appointment, the session will be considered a "No Call/No Show" AND your child will not be seen for their appointment.
- The client must meet overall attendance of 75%.
- MCRC does not follow the school district holiday schedule. Please check with your individual therapists to determine if you will have therapy during any school holiday.
- If a client misses 3 sessions without calling the Center *prior to their appointment time* ("No Call/No Show") it is an automatic discharge from therapy services.
- Missing more than 3 consecutive weeks of therapy may lead to loss of your treatment spot. If you have to miss 3 or more consecutive weeks, please discuss this with your therapist in advance.

Regarding **PRESCRIPTION REQUIREMENT:**

- Therapy services cannot be received unless a current written prescription from the treating physician is on file with MCRC.
- The prescription must be dated within the past 12 months and list the specific therapy disciplines (OT, PT, ST) to be received, along with a diagnosis.

Midland CHILDREN'S rehabilitation center

CONSENT TO TREAT

The State of Texas
County of Midland

WHEREAS, we the undersigned are the parents/guardians of

(Child's Name) _____DOB _____; and,

WHEREAS, we desire that the above named child receive treatment at the Midland Children's Rehabilitation Center in Midland, Texas (the "***MCRC***").

NOW, THEREFORE, in consideration of the terms, conditions and covenants herein below expressed, the parties agree as follows:

We hereby request that the MCRC furnish treatment for our child, at no cost or expense to us or to our child and the MCRC agrees to provide such treatment, free of charge.

In case of any character of injury or damage to our child arising out of any of the treatment or in any other way related to the MCRC, whether the same should occur at the MCRC or en route to or from the same, we the undersigned, hereby forever waive and release any and all claims which we or our child may now or hereafter have against any person in anywise connected with the MCRC or in any way acting for the MCRC as a part of our child's treatment program or in consideration of the treatment therefore given, or to be hereafter given to our child.

We hereby consent to the rendering of medical care which may include routine diagnostic procedures and such other medical treatment as deemed necessary or appropriate by any of our child's present or future physicians or clinicians, including, without limitation, medical clinics, wheelchair clinics, orthotic clinics, splinting and casting applications, occupational, speech and/or physical therapy intervention, aquatic therapy, equine assisted therapy and other MCRC sponsored activities.

_____ (Initial) Although general referrals to physicians and/or vendors are provided as a courtesy to our clients, MCRC does not endorse any physician or vendor over another. MCRC does not make any representations or representations about any physicians or vendors and cannot be held responsible for any interactions or treatments between you and the physician or vendor you choose.

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Witness Date

For Office Use Only
Reviewed by: _____ Parent's Initials: _____

Date: _____ Date: _____

Midland CHILDREN'S rehabilitation center

Authorization to Disclose Therapy Records

As parent and/or legal guardian of _____ DOB: _____

I specifically authorize the release of information specified below **only** to the individual(s) listed on this form.

☐ Complete Copy of All Records

☐ Telephone/verbal communication

☐ Counseling & Consultation Visits

☐ Condition and Dates of Visits

☐ Other, please specify: _____

Please list names and information of individuals, **including yourself and your spouse**, who have your permission to your child's medical records and information. If you wish to limit the access of any of the individuals named below beyond the above listed methods of communication, please include a note in the space(s) marked "Special Instructions" below.

1. Name: _____ Relationship to Child: _____

   Address: _____ Phone number: _____

   Special Instructions: _____

2. Name: _____ Relationship to Child: _____

   Address: _____ Phone number: _____

   Special Instructions: _____

3. Name: _____ Relationship to Child: _____

   Address: _____ Phone number: _____

   Special Instructions: _____

4. Name: _____ Relationship to Child: _____

   Address: _____ Phone number: _____

   Special Instructions: _____

☐ I understand that I have the right to revoke this authorization, but I must do so in writing and it will not apply to information previously released by the authority of this document.

☐ I also understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws.

☐ I understand authorizing the disclosure of the information identified above is voluntary.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Witness Date

Midland CHILDREN'S rehabilitation center

Attendance Policy/Prescription Requirement

Welcome to Midland Children's Rehabilitation Center. We are pleased that your child will be receiving services here at the center.

Midland Children's Rehabilitation Center is a 501(c)(3) non-profit organization supported by the generosity of the citizens of Midland and Texas. The vision of the board of directors is that children with disabilities should receive therapy services at MCRC at *no charge to the children or their families.* For this reason we have an extensive waiting list of children seeking our services. Therefore, **please review the following adopted policy:**

1. **If your child has three "No Call/No Show" (NCNS) appointments, they will be discharged from therapy and their slot will be given to the next child on the waiting list**. We know that some children have health and medical issues that may interfere with a regular therapy schedule. A non-traditional therapy schedule may be considered for those with severe health and medical issues which may consist of home exercise programs, less frequent therapy sessions (i.e. once a month), etc. Visit with your therapist about your child's particular scheduling needs and how you will deal with them, together. Please communicate with your therapist about a best plan for your child.

   MCRC's Attendance Policy is as follows:
   Each child is required to have an overall attendance rate of 75% for all treatment sessions per discipline seen. It is the responsibility of the parent to keep track of their child's attendance. Attendance will be evaluated by MCRC twice per year. If a child has three NCNS appointments or does not meet the 75% attendance rate, they will be discharged from therapy services and their therapy slot will be given to the next child on the waiting list. If you are unable to be on site and telehealth is offered to your family, please accept this option to avoid cancelations.

2. **Prescription Requirement: I understand that my child <u>cannot receive therapy services</u> unless there is a current written prescription from my child's primary care physician on file with MCRC. (The prescription for therapy must be dated within the past 12 months and list the specific therapy service my child is to receive along with a diagnosis.)**

3. **MCRC will not provide services to children who are currently receiving the same services (PT, OT or speech) with any other facility.** If your child is receiving services anywhere else, other than at school, please discuss with your therapist.

_____ _____ _____
Signature of Parent / Legal Guardian Date Name of Parent/Legal Guardian (Please Print)

For Office Use Only
Reviewed by: _____ Parent's Initials: _____

Date: _____ Date: _____

Midland CHILDREN'S rehabilitation center

Family Responsibility Agreement

Child's Name: _____ **DOB:** _____

Welcome to Midland Children's Rehabilitation Center (MCRC). To make the most out of the services at MCRC, it is important that you understand what we expect of our patients and their families.

Therapist Responsibilities:

1. Our goal is to provide each patient with the skills to function at their very best at home, in school and out in the community.
2. We will create a treatment plan specific to your child and his / her needs based on test results, identified strengths, identified weaknesses and goals set by the child's family.
3. We will provide open communication with the family regarding home program recommendations, supplemental services and other professionals that your child might need to see.

Family Responsibilities:

1. Before being seen for therapy, MCRC **MUST** have a current prescription for the specific type of therapy that is recommended.
2. Be on time to each appointment and evaluation.
    a. If more than 15 minutes late to an appointment, the session will be considered a "No Call/No Show".
    b. If you are more than 15 minutes late, the therapist will not see your child for their appointment.
3. The primary caregiver must be present for all OT, PT and ST evaluation(s).
4. Each patient should be dressed appropriately for the specific therapy they will be receiving.
5. Parents or guardians should stay at the clinic during treatment sessions in case of emergency. This will also allow the therapist to discuss the treatment session with you and recommend things to do at home.
6. Cell phones are not allowed in the treatment areas.
7. Share any changes in information (medical, phone number, address, etc.) with the front office staff.
8. For the best outcome, follow through with home recommendations made by the therapist.
9. To protect privacy, no photography, videos or audio recordings are allowed without prior approval from the treating therapist. This includes, but is not limited to cell phones, smart watches, cameras, or video cameras.
10. Complete all mandatory MCRC paperwork.

Attendance:

1. If you need to cancel your appointment or are going to be late, please call the office at (432) 498-2053 as soon as possible.
2. Please call to cancel your child's appointment if they have had vomiting, diarrhea, fever or any contagious illness within the 24 hours prior to their therapy appointment.

Reasons for Discharge:

1. All goals set by the therapist at the initial evaluation are met and therapy is no longer recommended.
2. A plateau has been reached regarding progress toward therapy goals.
3. Your child misses 3 therapy sessions without calling to cancel (This is considered a "No Call/No Show" for appointment).
4. Your child does not maintain an attendance rate of 75% for all treatment sessions.
5. The child's behavior prevents their ability to participate and make progress during therapy.
6. Child is receiving services (PT, OT, ST) at another facility - MCRC does not duplicate services.

I have read this agreement and understand my responsibilities and why they are important.

_____ _____ _____ _____

Signature of Parent / Legal Guardian Date MCRC Staff Date

Midland CHILDREN'S rehabilitation center

Parent Informed Consent for Student Therapists

Child's Name: ____________________ **DOB**: _______________________

Midland Children's Rehabilitation Center provides learning experiences for many students who are studying to become future physical, occupational, and speech therapists. We are proud to be considered a teaching facility and frequently have students who have come to MCRC for their pediatric rotation. While here at MCRC, each student therapist may have the opportunity to follow your child's therapist to observe various treatment sessions, to plan their own treatments for your child and eventually to lead the therapy session on their own with the supervising therapist nearby for assistance if needed.

Each child's care is our top priority. Your child will receive the same quality therapy and care with a student therapist as they would with their regular therapist. Therapists spend plenty of time supervising, training, and discussing your child's diagnosis and plan of care thoroughly. Your child's therapist will evaluate any possible safety concerns before the student therapist is allowed to work with your child by themselves.

It is of great benefit for your child to be seen by a student therapist. The student therapist will come with the latest research and will have a fresh set of eyes to try new therapy activities with your child. It will also benefit the patient to listen to and adjust to another adult.

— —

I understand that my child will at some point receive therapy services which will be provided by a student therapist at Midland Children's Rehabilitation Center. I understand that my child's therapist will be closely supervising the students; however, may not always be in the room during therapy sessions.

___________________________ ___________ ______________________ ___________
Signature of Parent / Legal Guardian Date MCRC Staff Date

____
Name of Parent/Legal Guardian (Please Print)

Midland CHILDREN'S rehabilitation center

MCRC Sick Policy

Child's Name: _____ **DOB**: _____

The health and well-being of our patients, their families, and our staff is very important to us at Midland Children's Rehabilitation Center (MCRC). In order to attend therapy sessions, your child must be symptom-free for 24 hours, without the use of medications. You should call to cancel your appointment if any of the following have occurred in the past 24 hours:

- Fever of 100.4 or higher
- Diarrhea
- Vomiting
- Body rash
- Uncontrollable coughing
- Wheezing or difficulty breathing
- Eye discharge
- Someone in your household has COVID-19 or is awaiting COVID-19 test results

Please note that sick individuals (including siblings/parents) should not be in the waiting room. Parents should use their best judgement regarding their child's ability to tolerate treatment sessions. You are responsible for calling and notifying MCRC of cancelation prior to your appointment time. Depending on your child's therapy and level of cooperation, telehealth may be offered as an alternative to in-person therapy. *MCRC reserves the right to end a session early if your child exhibits any of the above symptoms or if they cannot participate in their session*.

I have reviewed the above protocol and agree to notify MCRC immediately to cancel future appointments if any of the above information changes between visits or anyone in my household begins to show symptoms of illness.

_____ _____ _____

Signature of Parent / Legal Guardian Date Name of Parent/Legal Guardian (Please Print)

For Office Use Only

Reviewed by: _____ Parent's Initials: _____

Date: _____ Date: _____

Publicity Release for MCRC

Child's Name: ______________________ DOB: _________________

_____ I **do not** want my child's photograph to be used in any publicity by the Center.

____ I give my permission to the staff of Midland Children's Rehabilitation Center to utilize facts related to diagnosis and/or for my child to be photographed by the staff of MCRC, Newspaper Photographers and TV reporters for the purpose of: Staff training, fundraising and publicity materials to include but not limited to brochures, slideshows, newsletters, MCRC website, social media, TV and newspaper ads.

____ I acknowledge that photographs/videos of my child may be taken by therapists to demonstrate proper therapy techniques for my educational purposes.

This publicity release is granted from the date below and may be revoked or changed by the parent/guardian at any time by submitting a written request to Midland Children's Rehabilitation Center.

I have read and understand this document.

________________________________ ______________________

Signature of Parent/Legal Guardian Date

____

Name of Parent/Guardian (Please Print)

For Office Use Only

Reviewed by: __________ Parent's Initials: ___________

Date: ___________ Date: ___________

Midland CHILDREN'S rehabilitation center

Contact Information

Date Completed: _____

Name of person completing the Intake Packet: _____Relationship to child: _____
Are you the legal guardian? □ Yes □ No
If legal guardian is NOT a parent, you will need to provide proof of guardianship or medical conservatorship
Language(s) spoken in the home: _____

Child's Dominant Language:
English: _____
Other: _____

Prescribed Services: ____ Occupational Therapy
____ Physical Therapy
____ Speech Therapy

IDENTIFYING INFORMATION/ FAMILY HISTORY:

Child's Name: Last: _____ First: _____ MI: ____
Date of Birth: _____ Age: _____ Gender: ____Male _____Female
Street Address: _____
City: _____State: _____ Zip: _____
Primary Diagnosis: _____

Legal Guardian 1 Name/Relationship: _____ Age: ____
Address: _____
E-mail: _____
Cell #: _____ Home#: _____
Education: _____ Occupation: _____
Employer: _____ Work Phone #: _____
Work Address: _____

Legal Guardian 2 Name/Relationship: _____ Age: ____
Address: _____
E-mail: _____
Cell #: _____ Home#: _____
Education: _____ Occupation: _____
Employer: _____ Work Phone #: _____
Work Address: _____

Emergency Contact (other than parent or guardian):

Name: _____ Phone number:_____ Relationship:_____

Midland CHILDREN'S rehabilitation center

Demographics

The following information is required. Please answer **ALL** questions. MCRC offers services at no charge to our clients. However, we do have to seek funding from various sources including grants, foundations, and private donors. MCRC needs this information to present a clear picture of the population we serve.

What type of insurance do you currently have?

- ☐ No insurance
- ☐ Medicaid
- ☐ Private Insurance: _____
- ☐ SSI/Disability

What is your ethnicity?

- ☐ Asian
- ☐ Black or African American
- ☐ Native American
- ☐ Caucasian (Non-Hispanic)
- ☐ Hispanic/Latino
- ☐ Pacific Islander
- ☐ Others: _____

What is your Annual income?

- ☐ Less than $10,000
- ☐ $10,001-$20,000
- ☐ $20,001-$30,000
- ☐ $30,001-$40,000
- ☐ $40,001-$50,000
- ☐ $50,001-$60,000
- ☐ $60,001-$70,000
- ☐ $70,001-$80,000
- ☐ $80,001-$90,000
- ☐ $90,001-$100,000
- ☐ $100,001-$250,000
- ☐ $250,001 and over

How many people are in your household? _____

How did you hear about MCRC?

- ☐ Physician
- ☐ Hospital
- ☐ TV
- ☐ Internet
- ☐ Newspaper
- ☐ Employer
- ☐ Facebook
- ☐ Self
- ☐ Friend _____
- ☐ Other _____

What is the reason you are seeking services at MCRC? (check all that apply)

- ☐ Insurance ran out
- ☐ No longer qualify for Medicaid
- ☐ Do not have private insurance
- ☐ Medicaid is primary insurance
- ☐ Have insurance or other coverage, but prefer to come to MCRC
- ☐ It is the only facility that has the program we need
- ☐ Other_____

Would you like information on any of the following community resources?

- ☐ Pediatricians
- ☐ Specialists
- ☐ Social Services
- ☐ SHARE
- ☐ Other: _____

Please list your child's diagnoses:

_____

_____

_____

Midland CHILDREN'S rehabilitation center

Do you have specific goals for your child in the next 12 months that could be helped with therapy? (Please be more specific than "to get better")

Physical Therapy: *Addresses developmental delays and gross motor skills such as strengthening, balance, coordination, endurance, gait and range of motion.*

Goals:

_____

_____

Occupational Therapy: *Addresses fine motor skills such as grip and use of hands/upper extremities, sensory processing, and daily living tasks such as dressing, eating and transitions.*

Goals:

_____

_____

Speech Therapy: *Addresses language and communications concerns such as fluency, articulation and voice along with feeding and swallowing concerns.*

Goals:

_____

_____

Have you retained an attorney or are you considering attorney involvement in connection with the medical condition for which you are seeking treatment? ☐ Yes ☐ No

Are your child's immunizations/vaccinations up to date? ☐ Yes ☐ No

If no, please state the reason: _____

Has your child ever received or are they currently receiving any of the following therapies?

Physical Therapy	□ Yes □ No	ABA	□ Yes □ No
Occupational Therapy	□ Yes □ No	Myofunctional Therapy	□ Yes □ No
Speech Therapy	□ Yes □ No		

Midland CHILDREN'S rehabilitation center

FEEDING HISTORY

Date _____
Name of child _____
Date of birth _____ Age _____
Name of School attended _____
Type of Classroom _____
Name of person completing this form _____
Relationship to child _____

Please answer the following questions regarding your child's feeding skills:

In infancy, child was _____(breast fed, bottle fed, tube fed). If tube fed, why and for how long? _____
_____
_____
Was he/she on a ventilator? Yes _____ No _____ If yes, how long? _____
How long did early feedings last? _____
Were any strategies (i.e., positioning, external jaw/cheek support, different bottles, nipples, etc.) used to help with early feeding? If yes, explain. _____
_____
_____

If your child is fed orally:

When did he/she transition from formula/breast milk/Pediasure, etc. to baby foods (pureed)? _____
_____
When did he/she transition to textured foods? _____
When did he/she transition to soft solids? _____
When did he/she transition to solid foods? _____
What is his/her current diet? (Please provide amounts and types of a typical day's intake- both orally and by tube)
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Midland CHILDREN'S rehabilitation center

Check the following descriptions of behaviors/actions that are consistently exhibited (at least once per week) at the mealtime:

_____a poor appetite
_____disinterest in food
_____food refusal
_____extreme food "pickiness"
_____talks with mouth full
_____gagging with or without vomiting
_____mealtime tantrums
_____unusual food habits
_____food-texture selectivity
_____excessive overreacting
_____yells
_____whining or fussing at mealtimes
_____requests for non-served foods
_____takes food from another's tray/plate
_____gets out of seat
_____easily distracted from eating
_____throws food
_____"messy" eating; frequent spills
_____chews with mouth open
_____has ability, but doesn't use napkin
_____prefers liquid over solid food
_____poor eye contact with communication partner or feeder
_____doesn't keep hands to self
_____eats too fast
_____eats too slow
_____doesn't orient to feeder, but orients at other times
_____expelling of food
_____takes bites that are too large
_____exhibits self-stimulatory behavior at mealtime
_____talks too much at mealtime
_____takes bites that are too small
_____drinks too fast
_____ignores communication partner/ feeder

Check the following reactions that have been observed with eating:

□ Coughing How often per week, month, etc.? _____
□ Gagging How often per week, month, etc.? _____
□ Slow eating How often per week, month, etc.? _____
□ Choking How often per week, month, etc.? _____
□ Wet vocal quality How often per week, month, etc.? _____
□ Noisy breathing associated with feeding
How often per week, month, etc.? _____
□ Upper respiratory infections, pneumonias, etc.
How often per week, month, etc.? _____
□ Other physical signs associated with eating (i.e., heart rate, color changes, respiratory changes, weight loss, etc.)
Describe what has been observed and how often it has occurred in the past year: _____
_____
_____
□ Hospitalizations in the past year?
Why? _____
How long? _____

What is your child's current weight and height? _____

Midland CHILDREN'S rehabilitation center

Feeding Preferences and Current Practices

What is your child's preferred temperature for liquids? _____

- For foods traditionally served warm? _____
- For foods traditionally served cold? _____

Does your child prefer foods:

- With strong tastes? _____
- With bland tastes? _____
- Both? _____

Please list 4-5 of your child's favorite foods: _____
_____
_____

Please list 4-5 foods your child doesn't like: _____
_____
_____

Is your child's food modified for him/her (i.e., chopped, ground, pureed, etc.) If so, please explain: _____
_____
_____

Does your child receive any vitamin/mineral supplements? If so, please explain: _____
_____
_____

Does your child use any particular bowls, utensils, cups, etc.? If so, please describe: _____
_____
_____

Does your child sit in a special chair for meals? Yes _____ No _____ If yes, please explain: _____
_____
_____

Does your child need "help" with self-feeding? Yes _____ No _____

- With utensils? Yes _____ No _____
- With fingers? Yes _____ No _____

Does your child feed himself/herself? Yes _____ No _____
Is your child fed by others nearly 100% of the time? Yes _____ No _____

What are your goals for your child related to feeding/swallowing?
_____
_____
_____
_____

What are your primary concerns for your child related to feeding/swallowing?
_____
_____
_____
_____

Midland CHILDREN'S rehabilitation center

FLUENCY QUESTIONAIRE

When was stuttering first noticed?

_____

Who first noticed the child's stuttering?

_____

Was the onset sudden (over one-seven days) or gradual (two weeks or more)?

_____

In your opinion, what was the most important cause of the stuttering?

_____

Indicate whether or not the following behaviors or characteristics are observed when your child is stuttering:

Behavior	**Never**	**Sometimes**	**Frequently**
Repeating sound/syllable (ba-ba-baby)	1	2	3
Repeating short words (and-and)	1	2	3
Repeating phrases or longer words	1	2	3
Prolonging vowels (aaa)	1	2	3
Prolonging consonants (sss, mmm)	1	2	3
Silent blocks (b-aby)	1	2	3
Abandoned words (ba-)	1	2	3
Revisions (I want) I need to go	1	2	3
Interjecting (ah, um)	1	2	3
Other_____	1	2	3

Have you observed any of the following behaviors or characteristics in your child's current speech?

Behavior	**Never**	**Sometimes**	**Frequently**
Facial Grimaces	1	2	3
Eye closing/blink	1	2	3
Eyes wide open	1	2	3
Tense	1	2	3
Tense tongue	1	2	3
Wide-opened mouth	1	2	3
Tension in jaw	1	2	3
Tremor in lips, jaw	1	2	3
Tension in throat	1	2	3
Respiratory irregularities	1	2	3
Upward swings in vocal pitch	1	2	3
Tilt head	1	2	3

Behavior	Never	Sometimes	Frequently
Tense movement of arms/legs	1	2	3
Loss of eye contact with listener	1	2	3
Giving up on talking	1	2	3
Comments about speech difficulty	1	2	3

What did you do when you first noticed your child's stuttering?

_____

How has your child's fluency changed since its onset?

_____

Is your child stuttering primarily on the first words of sentences or on words throughout the sentence?

_____

Do you feel your child is aware of stuttering? If yes, please explain.

_____

Describe situations in which your child's stuttering is worse:

_____

_____

Is there a history is stuttering in the family? If yes, please explain.

_____

What would your goals be if your child was enrolled in therapy for stuttering?

_____

_____