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| Intellectual disability, autism spectrum disorder and physical disability programs | Services request  Stuttering  PARENTS SECTION |
| MUST BE FILLED IN BY A PARENT | |

Electronic version

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| 1. Child identification | |  | |
| Last name | First name | | Date of birth |

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| 1. **Daily impacts** |  |
| Does your child have difficulty making requests because of his/her stuttering? | |
| Never  Rarely  Sometimes  Often  Always | |
| Please specify : | |
| Does the stuttering make it difficult for you to understand your child when he/she speaks to you? | |
| Never  Rarely  Sometimes  Often  Always | |
| Please specify : | |
| How does your child react to the stuttering: | |
| Does he continue his/her sentence?  Never  Rarely  Sometimes  Often  Always | |
| Does he/she get mad?  Never  Rarely  Sometimes  Often  Always | |
| Does he/she stop talking?  Never  Rarely  Sometimes  Often  Always | |
| Does he/she change the sentence?  Never  Rarely  Sometimes  Often  Always | |

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| Does he have any other reactions? | | | |
| If these reactions are problematic, please explain: | | | |
| Does your child get teased due to the stuttering? | | | Yes  No |  |
| Is your child aware of his or her stuttering? | | | Yes  No |
| Does your child avoid speaking in certain situations because of his or her stuttering?  Never  Rarely  Sometimes  Often  Always | | | |
| Give details (where, when, etc.): | | | |
| Are there any other issues that concern you?  If yes, please give details: | | | |
| 1. **Motivation** |  | | |
| Who saw the need to seek help for your child's stuttering? | | | |
| Yourself  Your child | | Someone else : | |

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| Stuttering services include:   1. Participation in meetings at the Jewish Rehabilitation Hospital of the CISSS de Laval; 2. Exercise at home several times a week. | | | | | | |
| Your motivation (or availability) to do this is: | | | | | | |
|  | 1 | 2 | 3 | 4 | 5 |  |
|  | None | Weak | Average | Good | Excellent |  |
| Your child's motivation (or availability) to do this is: | | | | | | |
|  | 1 | 2 | 3 | 4 | 5 |  |
|  | None | Weak | Average | Good | Excellent |  |
|  | | | | | | |

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| Parent who filled out the form |  |
| LAST, FIRST NAME |  |
| Parent's signature | Date |