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| Intellectual disability, autism spectrum disorder and physical disability programs | Services requestStutteringPARENTS 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 |