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Tools for "Taking Stock"

Instructions: After each of the following questions, please circle the number that best represents your opinion. Be as honest as you can. There are no right or wrong answers.

1. Overall, how much **DIFFICULTY, HANDICAP, OR SUFFERING** do you experience from your stuttering *at this time.*

1	2	3	4	5	6	7	8	9	?
None				*Moderate*				*Very Much*	*I Don't Know*

2. Overall, how much does your stuttering **NEGATIVELY AFFECT YOUR ABILITY TO INTERACT WITH OTHER PEOPLE** *at this time?*

1	2	3	4	5	6	7	8	9	?
No Negative Effect				*Moderate Negative Effect*				*Extreme Negative Effect*	*I Don't Know*

now

3. Overall, how much do you **FEEL ABLE OR UNABLE TO CONTROL YOUR STUTTERING** *at this time?*

1	2	3	4	5	6	7	8	9	?
Completely Able to Control				*Equally Able or Unable to Control*				*Completely Unable to Control*	*I Don't Know*

4. Overall, how **SEVERE** is your stuttering *at this time?*

1	2	3	4	5	6	7	8	9	?
No Stuttering				*Very Mild*				*Very Severe*	*I Don't Know*

5. Overall, how much do you **FEEL A NEED OR DESIRE TO GET HELP** for your stuttering *at this time?*

1	2	3	4	5	6	7	8	9	?
None				*Moderate*				*Very Much*	*I Don't Know*

6. **HOW IMPORTANT A PROBLEM IS STUTTERING IN YOUR LIFE** *at this time?*

1	2	3	4	5	6	7	8	9	?
Not Important At All				*Moderate*				*Very Important*	*I Don't Know*

For older persons who stutter *(SL♦ILP-S)*—side 1 of 2 ▲

parent's judgment

8. Overall, how much do you think your child **FEELS INCLINED TO ASSOCIATE WITH OTHER PEOPLE WHO STUTTER** *at this time?*

1	2	3	4	5	6	7	8	9	?
Not At All				*Moderate*				*Very Much*	*I Don't Know*

9. Overall, how much do you think your child **FEELS INCLINED TO HELP OTHER PEOPLE WHO STUTTER** *at this time?*

1	2	3	4	5	6	7	8	9	?
Not At All				*Moderate*				*Very Much*	*I Don't Know*

10. Overall, how do you think your child would rate his/her **PHYSICAL HEALTH** *at this time?*

1	2	3	4	5	6	7	8	9	?
Very Poor				*Not Poor but Not Good*				*Excellent*	*I Don't Know*

11. Overall, how do you think your child would rate his/her **MENTAL HEALTH** *at this time?*

1	2	3	4	5	6	7	8	9	?
Very Poor				*Not Poor but Not Good*				*Excellent*	*I Don't Know*

12. Overall, how **SATISFIED DO YOU THINK YOUR CHILD IS WITH HIS/HER LIFE** *at this time?*

1	2	3	4	5	6	7	8	9	?
Highly Unsatisfied				*Not Unsatisfied but Not Satisfied*				*Highly Satisfied*	*I Don't Know*

13. Overall, how much do you think your child's **STUTTERING WOULD AFFECT HIS/HER ANSWER ON THE PREVIOUS QUESTION,** No. 12. above?

1	2	3	4	5	6	7	8	9	?
No Effect on #12				*Moderate Effect on #12*				*Completely Determined #12*	*I Don't Know*

This form completed by: _____
(Name / Relationship to the Child)

For children who stutter *(SL♦ILP-S/C)*—side 2 of 2 ▲

"Recollections" *(SL♦ILP-S/R)*—side 1 of 2 ▼

St. Louis Inventory of Life Perspectives and Stuttering/Recollections (SL•ILP-S/R)
A **Taking Stock** Self-Study Exercise • Kenneth O. St. Louis, Ph.D.

Name: Age: Date:

Circle or write the time period in the past selected for rating:

around 10 years old high school other: _____

Instructions: After each of the following questions, please circle the number that represents your current best guess of how you think you would have filled out the inventory at that time in the past indicated above. Be as honest as you can. There are no right or wrong answers.

1. Overall, how much **DIFFICULTY, HANDICAP, OR SUFFERING** did you experience from your stuttering *at that time.*

1	2	3	4	5	6	7	8	9	?
None				*Moderate*				*Very Much*	*I Don't Know*

2. Overall, how much did your stuttering **NEGATIVELY AFFECT YOUR ABILITY TO INTERACT WITH OTHER PEOPLE** *at that time?*

1	2	3	4	5	6	7	8	9	?
No Negative Effect				*Moderate Negative Effect*				*Extreme Negative Effect*	*I Don't Know*

earlier

3. Overall, how much did you **FEEL ABLE OR UNABLE TO CONTROL YOUR STUTTERING** *at that time?*

1	2	3	4	5	6	7	8	9	?
Completely Able to Control				*Equally Able or Unable to Control*				*Completely Unable to Control*	*I Don't Know*

4. Overall, how **SEVERE** was your stuttering *at that time?*

1	2	3	4	5	6	7	8	9	?
No Stuttering				*Very Mild*				*Very Severe*	*I Don't Know*

5. Overall, how much did you **FEEL A NEED OR DESIRE TO GET HELP** for your stuttering *at that time?*

1	2	3	4	5	6	7	8	9	?
None				*Moderate*				*Very Much*	*I Don't Know*

Comparisons by category over time—side 1 of 1 ▼

SL•ILP-S Scoring Summary Sheet
A **Taking Stock** Self-Study Exercise • Kenneth O. St. Louis, Ph.D.

Name: Age: Date:

Key: ◯ Now ☐ High School △ 10 years old, or other: _____

Instructions:

1) Circle the numbers on this *Scoring Summary Sheet* rated on the *SL•ILP-S* (or *SL•ILP-S/C*). Begin with the last item (# 13) and then proceed circling numbers rated for #1 through #12.
2) Connect these numbers within each of the three categories on the *Scoring Summary Sheet* with solid lines.
3) Add the seven circled numbers located within the square in the category labeled "Your Stuttering and Its Effect on You" to determine the *Total Effect Score.* Write that number in the space provided at the right.
4) If applicable, repeat steps 1 – 3 for the *SL•ILP-S/R* for ratings during high school. Draw boxes around each number on the *Scoring Summary Sheet* and connect with short dotted lines. Calculate and record the *Total Effect Score.*
5) If applicable, repeat steps 1 – 3 for the *SL•ILP-S/R* for ratings when about 10 years old (or other age). Draw triangles around each number on the *Scoring Summary Sheet* and connect with longer dotted lines. Calculate and record the *Total Effect Score.*

Please see *Appendix H: Taking Stock: Assessing Your Life Perspectives and Stuttering* in St. Louis, K. O. (Ed.). *Living with Stuttering: Stories, Basics, Resources, and Hope* (#T1) for background, examples, and information on interpretation.

Your Stuttering and Its Effect on You	No Concern	Minimal Concern	Moderate Concern	Substantial Concern	Extreme Concern
13. EFFECTS OF STUTTERING ON LIFE SATISFACTION					
1. DIFFICULTY, HANDICAP, OR SUFFERING					
2. NEGATIVE EFFECTS ON INTERACTIONS					
3. UNABLE TO CONTROL STUTTERING					
4. SEVERITY OF STUTTERING					
5. NEED OR DESIRE TO GET HELP					
6. IMPORTANCE IN YOUR LIFE					
7. IMPORTANCE IN LIVES OF PEOPLE YOU LIVE WITH					

Your Interest in Others Who Stutter	Very Likely	Quite Likely	Neither Likely Nor Unlikely	Quite Unlikely	Very Unlikely
8. INCLINED TO ASSOCIATE WITH OTHERS WHO STUTTER					
9. INCLINED TO HELP OTHERS WHO STUTTER					

Your Health and Life Satisfaction	Excellent	Good	Neither Poor Nor Good	Poor	Very Poor
10. PHYSICAL HEALTH					
11. MENTAL HEALTH					
12. SATISFACTION WITH LIFE					