SDSU College of Health and Human Services
School of Speech, Language, and Hearing Sciences
Speech-Language Clinic
5500 Campanile Drive, San Diego, CA 92182-1518
619-594-7747
FAX: 619-594-7790

Date of Application_____

1. Name of Applicant_____ Date of Birth_____

2. Address_____ Phone_____
(number, street) (city) (zip code)

3. Name of Person Completing this Application_____
Relationship to Client_____ Phone_____ Email_____

4. Who referred applicant to the clinic?_____
Relationship to client:_____

5. Has the applicant received any program of speech assessment or therapy before? Yes_____ No_____
If yes, when and from whom?_____

6. Please list schools applicant has attended:
School_____ Address_____
Dates of Attendance_____ Grades_____
School_____ Address_____
Dates of Attendance_____ Grades_____

7. Has the applicant ever had a psychological assessment (intelligence or mental health evaluation)? Yes___ No____
If yes, when and from whom?_____
Results:_____
_____

8. Has the applicant had a medical examination in the last twelve months? Yes_____ No_____
If yes, describe the results:_____

9. Has the applicant had a hearing test in the last twelve months? Yes_____ No_____
If yes, describe the results:_____

10. Describe the applicant's present speech pattern. Several may apply; check as many as necessary.
    a. _____Says nothing.
    b. _____Rarely speaks.
    c. _____Talks a little but is not understood by most people.
    d. _____Talks a lot but is not understood by most people.
    e. _____Talks freely, but language is that of a younger child.
    f. _____Does not seem to understand language when spoken to.
    g. _____Does not produce many speech sounds correctly.
    h. _____Talks through his or her nose.
    i. _____Stutters or stammers.
    j. _____Repeats many words, sounds, or syllables.
    k. _____Pauses a great deal when speaking; seems to have trouble getting the words out
    l. _____Seems to have difficulty coming up with desired words.

Please describe the patient's speech/language problems_____
_____
_____

11. The following statements pertain to the applicant's early vocal/verbal behavior. Read statements carefully and circle either "Yes" or "No" for each item, even though you may not be able to recall exactly.

    As a baby, the applicant:
    a. Babbled and cooed after feeding and during other periods of contentment……Yes__ / No__
    b. Babbled and cooed when playing alone……Yes__ / No__
    c. Carried on "imitative conversations" in jargon, or in words/sounds you did not understand….Yes__ / No__
    d. Echoed and mimicked your words……..Yes__ / No__
    e. Stopped babbling, imitating you, or using jargon for a certain period of time……..Yes__ / No__

12. How old was the applicant when he/she:
    a. said his/her first words?_____
       What were they?_____
    b. began using two to three word phrases?_____
       What were they?_____
    c. sat unassisted?_____
    d. began crawling?_____
    e. started walking?_____

13. Has the applicant's speech problem been diagnosed as resulting from a physical abnormality? Yes_____ No____
    If yes, please describe_____
    Who made this diagnosis?_____When?_____

14. Have languages other than English been spoken in the home? Yes_____ No_____
    If yes, which ones?_____

15. When and under what circumstances did you first become aware of the applicant's speech problems? (Please include as much detail as possible)_____
    _____
    _____

16. Did the applicant's speech problem develop: Gradually_____ Suddenly_____
    Has the applicant's speech problem: Improved_____Remained the Same_____ Become worse_____

17. Does the applicant's speech problem become more severe under certain circumstances? Yes_____ No____
    If yes, please explain_____
    _____

18. Has anything been done in the home to correct the speech problem? Yes_____ No_____
    If yes, please explain_____
    _____

19. What do you feel is the cause of the applicant's speech problem?_____
    _____

20. Is the applicant aware of his/her speech problem? Yes_____ No_____
    If yes, how does he/she feel about it?_____
    _____

21. Has the applicant's speech problem affected his/her relationship with others? Yes_____ No_____
    If yes, please explain_____
    _____

22. The following items refer to conditions before and during the birth of the applicant:
    a. What was the length of pregnancy?_____
    b. During pregnancy, did the mother have any health or emotional problems? Yes_____No_____
       If yes, please describe:_____
    c. Is the mother Rh negative? Yes_____ No_____

d. Age of mother at time of applicant's birth:_____
e. How long was labor?_____
f. Was the delivery by caesarean section? Yes___ No___
g. What was the birth weight?_____
h. What was the attending physician's evaluation of the baby's condition at birth? (include Apgar score)_____

23. a. Was the applicant breast-fed? Yes_____ No____. If Yes, for how long?_____
b. Was the applicant bottle fed? Yes_____ No____. If Yes, for how long?_____
c. Did the applicant have any feeding or weaning difficulties? Yes / No
If yes, please describe:_____
d. Any feeding problems now (chewing, swallowing, sucking through a straw)? Yes_____ No_____
If yes, please explain:_____

24. Has bedwetting occurred since toilet training was completed? Yes_____ No____. If yes, give the age and time span of episodes of bedwetting, and please state what was done about it:_____

25. Has the applicant ever sucked his/her fingers? Yes_____ No____. If yes, at what age and under what circumstances:_____
How were these problems handled?_____

26. Does the applicant presently have any health problems? Yes____ No____. If yes, please describe:_____

27. a. Has the applicant had any injuries or operations? Yes_____ No____. If yes, please describe:_____

b. Has the applicant ever been hospitalized? Yes_____ No____. If yes, please explain nature of illness and hospitalization: _____

28. Has the applicant had any of the illnesses listed below?

Measles	Yes___	No___	Age___	Mild___	Severe___
Mumps	Yes___	No___	Age___	Mild___	Severe___
Pneumonia	Yes___	No___	Age___	Mild___	Severe___
Tonsillitis	Yes___	No___	Age___	Mild___	Severe___
Ear infections	Yes___	No___	Age___	Mild___	Severe___
Hay Fever	Yes___	No___	Age___	Mild___	Severe___
Other allergies	Yes___	No___	Age___	Mild___	Severe___
Asthma	Yes___	No___	Age___	Mild___	Severe___
Flu	Yes___	No___	Age___	Mild___	Severe___
Frequent colds	Yes___	No___	Age___	Mild___	Severe___
High fevers	Yes___	No___	Age___	Mild___	Severe___
Convulsions/Seizures	Yes___	No___	Age___	Mild___	Severe___
Epilepsy	Yes___	No___	Age___	Mild___	Severe___
Stomach trouble	Yes___	No___	Age___	Mild___	Severe___
Gland trouble	Yes___	No___	Age___	Mild___	Severe___
Heart trouble	Yes___	No___	Age___	Mild___	Severe___

Other:_____

29. Did the applicant have any after-effects of any illnesses noted above? Yes_____ No____ If yes, please explain:

30. Is the applicant living with other than his/her natural parents? Yes_____ No____ If yes, please explain:_____

31. Does anyone in the applicant's family or environment have a speech or hearing problem? Yes_____ No____
    If yes, please state the relationship to applicant and give a brief description of that person's communication problem:
    _____

32. Parent/Guardian:_____ Age:_____
    Education:_____Occupation:_____
    Employer:_____

33. Parent/Guardian:_____ Age:_____
    Education:_____Occupation:_____
    Employer:_____

34. a. Who was the applicant's primary caretaker from:
       Birth to one year?_____
       One to two years?_____
    b. If applicant went to daycare, give hours spent there daily_____

35. Please list all household members currently living with the applicant:

Name	Age	Relationship to Applicant

Due to the overwhelming number of applications received, most applicants spend 2-3 semesters on our waiting list. Amount of time on the waiting list is determined by multiple factors, including but not limited to the severity of your child's communication impairment and the training needs of our graduate students. If you are hoping to enroll your child in therapy in the immediate future, please consult the list of local resources included in this packet.

If your child has received a full speech-language evaluation through your local school district, hospital, or private practice within the past calendar year, they *may* be eligible to begin therapy at the clinic without undergoing an evaluation here. **It is essential that you include a copy of the evaluation report with your application.**

If your child has not been evaluated within the past calendar year, it is likely that the first step toward receiving services at our clinic will be a full diagnostic evaluation conducted by our graduate students. If therapy is recommended, services typically begin the semester following the evaluation.

THANK YOU FOR BEING SO COMPLETE IN FILLING OUT THIS FORM.