



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:\_\_\_\_\_

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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.**