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

Initial Application Form – Adult Speech/Language/Cognition

Not all of the following questions may apply to you. Please fill out the application as completely as possible. Thank you.

Date of Application_____

1. Name_____ Age_____ Date of Birth _____

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

3. Home Phone_____Cell/Work phone_____Email_____

4. Contact Person _____ Relationship _____

Address (if different) _____ Phone _____

5. Person Filling out this application _____

Relationship to Applicant _____ Phone _____

6. Who referred you to the clinic?_____

Applicant Background

7. Reason for requesting services (check all that apply)

Aphasia	_____	Fluency/stuttering	_____
Memory problems	_____	Voice problems	_____
Cognitive problems	_____	Language learning problems	_____
Speech problems	_____	Accent Modification	_____
		How old were you when you came to the U.S.	_____

8. Is the Applicant's communication problem caused by a medical condition? Yes _____ No _____

9. If the answer to #8 is yes, please answer the following questions:

9a. Did the Applicant have a ☐stroke? ☐ brain injury? ☐ other?_____

9b. Date that the above occurred _____ Age at that time _____

9c. Hospital (acute) _____ Physician at that time _____

9d. Rehabilitation setting _____

10. Please fully describe the nature of the Applicant's communication problems: _____

_____

_____

_____

_____

11. Does the Applicant exhibit: ☐Right-sided weakness/paralysis ☐ Left-sided weakness/paralysis

☐Seizures If yes, date of last seizure:_____ ☐ Loss of vision

Does the Applicant wear glasses?_____ Has he/she had a vision exam since the event? ☐ Yes ☐ No

Does the Applicant have a hearing loss?__ Does he/she wear a hearing aid?_____ ☐Right ear ☐Left ear

Handedness (prior to injury): ☐ Right ☐ Left

12. Does the Applicant use a wheelchair? _____ Walker? _____ Cane? _____

13. Has the Applicant had a CT or MRI brain scan? ☐ Yes ☐ No
If yes, what were the results?_____

14. Is there a history of any of the following?

	Yes	No	Describe:
Communication Disorder			
Memory Impairment			
Previous Brain Injury			
Previous Stroke			
Clinical Depression			
Psychiatric Problems			
Alcohol Abuse/Problems			
Substance Abuse			
Dementia			
Other Neurological Diseases			
Heart Problems			
School/learning problems			

15. Applicant's primary language _____ Other language(s) used: _____

16. If the Applicant is <u>not</u> a native English speaker, has his/her skills in English affected: (check all that apply)
Employment _____ Social interactions _____ Education _____

17. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

18. Number of Children:_____

19. What is the Applicant's highest level of education?_____

Degree received, major field of study, graduation date _____

20. Is the Applicant currently employed? ☐ Yes ☐ No If Yes, please fill in the following information:

Name/Location of employer: _____

Job title:_____ How long employed:_____

If No, please fill in any previous place and duration of employment (# of years):

_____

21. List Applicant's interests, hobbies and leisure-time activities _____

_____

22. Who is currently living at home with the Applicant?

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Pets _____

Medical History

23. Has the Applicant had a medical examination in the past 12 months? ☐ Yes ☐ No
If yes, please fill out the following information:

Name of Doctor:_____ Type of Doctor (Specialty):_____

Address of Doctor:_____

24. Has the Applicant had Neuropsychological examination? ☐Yes ☐No
If yes, please fill in the following information:

Name of Doctor:_____

Address of Doctor:_____

Results of Testing:_____

25. Has the Applicant received any speech therapy? ☐ Yes ☐ No

If yes, please state when (dates):_____, Where_____
_____

Therapist's name and contact information: _____

_____

26. Is there other information we should know about the Applicant's medical, social, or communication history?

_____

_____

_____

Thank you for being so complete!

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