UNIVERSITY OF Redlands
Truesdail Center for Communicative Disorders
1200 East Colton Ave., P.O. Box 3080, Redlands, CA 92373-0999
Phone: 909-748-8061

ADULT APPLICATION FOR SERVICES

Date of Application: _____

(Please Print or Type

Name of Applicant: _____ Best contact number

Address: _____ Home phone: _____ ☐

City: _____ State: ____ Zip: _____ Cellular phone: _____ ☐

E-mail Address: _____ Work phone: _____ ☐

Birth date: _____ Sex: Male ☐ Female ☐

Marital Status: _____ Spouse's Name : _____

In case of emergency

Name: _____ Phone #: _____ Relationship: _____

Services Requested:

A. Please check all that apply:

☐ Speech/Language Evaluation ☐ Hearing Evaluation

☐ Speech/Language Therapy ☐ Hearing Therapy

☐ Other: _____

B. Please describe the speech, language or hearing problem in the space below:

_____

_____

_____

C. When was the onset of your communication impairment? When was the problem first noticed?

_____

_____

D. Please explain what help you expect this Center to provide for you.

_____

_____

_____

Medical History:

A. Provide medical history of neurological, psychological, learning and/or hereditary problems:

_____

_____

Major illnesses (include year):_____

_____

Major surgeries (include year):_____

_____

History of Seizures (frequency, medical management):_____

B. List current medications:

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

C. Applicant's Physician _____

Address: _____ Telephone _____

Please provide us with names and addresses of specialists or agencies that have examined or worked with the applicant.

Name: _____ Address: _____

Specialty: _____ Telephone: _____

Name: _____ Address: _____

Specialty: _____ Telephone: _____

Name: _____ Address: _____

Specialty: _____ Telephone: _____

Name: _____ Address: _____

Specialty: _____ Telephone: _____

Educational, Therapy and Social History:

A. Level of Education completed: _____

B. Occupation: _____

C. Language(s) spoken (primary/secondary): _____

D. Speech, Language, Swallowing and Hearing Services previously received:

_____

_____

E. Interest/Hobbies: _____

Additional Information: In the space below, please give us any additional information that you think will help us to understand the nature and effect of the applicant's problem.

_____

_____

_____

Name of person completing this form _____

Relationship to applicant _____

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AUDIO-VISUAL RELEASE

The Truesdail Center for Communicative Disorders at the University of Redlands is a training clinic for advanced students in Speech-Language Pathology and Audiology under the close supervision of qualified and certified faculty. In such a program, to provide the best educational experience, it is necessary to study photographs and audio-video recordings of diagnostic and therapy sessions. In some instances, educational studies are conducted in order to gain further knowledge of speech, language and hearing problems.

I understand and consent to the use of my name/my child's name, likeness, with or without voice, in which I/my child have, or may have been included in whole or part in audio-video recordings or photographs for the purposes of education and professional presentations. Periodically photographs are used for publicity purposes in brochures and on web-sites. It is acknowledged that I agree to waive compensation for such consent and that these images are the property of the Truesdail Center for Communicative Disorders. There will be no restrictions on the number of times that my image/my child's image may be used.

I am willing to have _____ participate in the program as described above.
(Client's Name)

Your signature below indicates your willingness to give consent and participate in the program.

_____ _____
Signature of Client, Parent or Guardian Date

Thank you for your assistance in this educational program.