UNIVERSITY OF Redlands | Truesdail Center for Communicative Disorders

1200 East Colton Avenue, P.O. Box 3080, Redlands, CA 92373-0999
Phone: 909-748-8061

Application for Services

CLIENT INFORMATION

Application Date: _____

Child's Name: _____

Date of Birth: _____ _____ Male _____ Female

Address: _____
Street City State Zip

Telephone: Home: _____ Cell: _____

Work: _____ E-mail: _____

Indicate best number and time to be reached: _____

Mother's Name: _____ Father's Name: _____

Mother's Occupation: _____ Father's Occupation: _____

Child lives primarily with: _____

Medical decisions made by: ☐ Both parents ☐ One parent: _____

Who referred you to the Truesdail Center, or how did you learn about us? _____

Services Requested: ☐ evaluation ☐ evaluation & treatment ☐ consultation

AREAS OF CONCERN (check all that apply)

- ☐ Academic skills
- ☐ Difficulty saying certain sounds
- ☐ Feeding or Swallowing
- ☐ Following Directions
- ☐ Hearing
- ☐ Hoarse voice
- ☐ Hyper-nasal voice
- ☐ Learning new skills
- ☐ Putting words together
- ☐ Social Skills
- ☐ Stuttering/Fluency
- ☐ Understanding his/her speech
- ☐ Understanding what others say

CLIENT HISTORY

Describe in your own words the type of difficulty your child is having: _____

_____

_____

When was the problem first noticed? _____

Has your child received any of the following diagnoses or been identified with any of the following? (check all that apply)

- ☐ ADHD
- ☐ Autism Spectrum Disorder
- ☐ Behavioral Disorder
- ☐ Cerebral Palsy
- ☐ Childhood Apraxia of Speech
- ☐ Cleft lip and/or palate
- ☐ Developmental Delay
- ☐ Fluency Disorder
- ☐ Hearing Impairment
- ☐ Intellectual Disability
- ☐ Language Disorder
- ☐ Learning Disability
- ☐ Speech/Articulation Disorder
- ☐ Traumatic Brain Injury
- ☐ Voice Disorder

If you have checked any of the above, please provide us with documentation of those diagnoses or concerns along with this application. Documentation may include IEPs, IFSPs, educational evaluations, medical records, therapy reports, etc.

Is your child aware of the problem? ☐ No ☐ Yes *If yes, how does your child feel about it?* _____

_____

FAMILY INFORMATION

	Name	Name	Name
Siblings			
Date of Birth			
Gender			
School Grade			
General Health			
Learning Difficulties	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Physical Disabilities	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Is there any history of communication, learning, neurological, psychological or other health problems in the immediate family or mother/father's extended families (aunts, uncles, cousins)? ☐ No ☐ Yes
If yes, please describe: _____

_____

LANGUAGE EXPERIENCES

If your child has only experienced English, please go to the next section

Below, indicate what languages your child has been exposed to and at what age (be sure to include current). Also, indicate how often the child is exposed to other languages, and during what contexts (e.g., meal time, family gatherings, school, home only, etc.).

Language	From What Age	Spoken/Signed By	Hours Per Day	During What Activities

ADOPTION INFORMATION

Is your child adopted? ☐ No ☐ Yes *If no, go to the next section.*

At what age did your child join your family? _____

Adoption Type: Domestic ☐ International ☐ Indicate country: _____

What changes in communication skills have you seen since your child became a member of your family? _____

_____

HEALTH & MEDICAL HISTORY

Has your child ever been examined by any of the following professionals:

PROVIDER	Dates of Service	Name of Provider	Currently under Provider's care
Audiologist			☐ No ☐ Yes
Behavior Specialist			☐ No ☐ Yes
Cardiologist			☐ No ☐ Yes
Developmental Pediatrician			☐ No ☐ Yes
Neurologist			☐ No ☐ Yes
Occupational Therapist			☐ No ☐ Yes
Orthopedic Physician			☐ No ☐ Yes
Otolaryngologist (ENT)			☐ No ☐ Yes
Physical Therapist			☐ No ☐ Yes
Psychologist			☐ No ☐ Yes
Speech-Language Pathologist			☐ No ☐ Yes
Social Worker			☐ No ☐ Yes
Other:			☐ No ☐ Yes
Other:			☐ No ☐ Yes

Primary Care Provider: _____

Is your child currently on any medications? ☐ No ☐ Yes

If yes, list names, schedule of medications and for what conditions.

Medication Name	Dosage	Condition for which medication is taken

List any nutritional supplements that your child takes: _____

_____

List any illnesses, past or current medical conditions, or syndromes: _____

_____

Indicate if your child has had any of the following:

Illness	Age	Type of Treatment	Illness	Age	Type of Treatment
Adenoidectomy			Influenza		
Allergies			Measles		
Anoxia			Meningitis		
Asthma			Mumps		
Blood Disease			Muscle Disorder		
Chicken Pox			Nerve Disorder		
Dental Problems			Pneumonia		
Ear Infections			Reflux		
Eczema			Seizures (non-febrile)		
Encephalitis			Strabismus		
Head Injury			Tonsillectomy		
Headaches			Vision Problems		
Heart Problems			Whooping Cough		

Has your child had any seizures? ☐ No ☐ Yes *If yes, at what age?* _____

What was the type of seizures? (such as febrile due to high fever; complex partial, etc.): _____

_____

Hospitalizations/Surgeries

Condition/Reason	Age

Describe any complications which occurred during hospitalizations/surgeries: _____

_____

_____

Were any of the above complications followed by noticeable changes in your child's general behavior or in his/her communication? If so, explain: _____

_____

ALLERGIES

Does your child have any **skin** allergies? ☐ No ☐ Yes To Latex? ☐ No ☐ Yes

To what?_____ Reactions: _____

Treatment : _____

Does your child have any **food** allergies? ☐ No ☐ Yes

If yes, please list: _____

Does your child have any allergies to **medications**? ☐ No ☐ Yes

If yes, please list: _____

CURRENT BEHAVIOR

How would you describe your child? (check *all* that apply):

☐ Aggressive	☐ Drowsy	☐ Happy	☐ Outgoing
☐ Clumsy	☐ Easily distracted	☐ Imaginative	☐ Quiet
☐ Cuddly	☐ Forgetful	☐ Impulsive	☐ Shy
☐ Curious	☐ Friendly	☐ Moody	☐ Tires Easily

Does your child have *difficulty* with any of the following? (check *all* that apply):

☐ Communicating feelings appropriately	☐ Problem solving and discussing options with others
☐ Dresses self easily	☐ Recognizing clean/soiled clothing
☐ Engaging in play with self	☐ Structuring free time
☐ Feeding self appropriately	☐ Taking care of personal belongings
☐ Following rules of games	☐ Taking care of personal hygiene
☐ Play with others easily	☐ Toileting self

Describe your child's strengths: _____

_____

_____

Does your child show aversive reaction to touching certain objects or textures? ☐ No ☐ Yes

If yes, please describe: _____

_____

Describe any problems in bowel or bladder control: _____

Describe any sleeping problems: _____

PRENATAL & BIRTH HISTORY

If you do not have information about your child's birth history please indicate "unknown": _____

Length of Pregnancy (in weeks): _____ Birth weight: _____

Were there any problems during or after the delivery? ☐ No ☐ Yes *If yes, please describe*: _____

_____

Please indicate if any health problems listed below occurred immediately after birth or during the first 2 weeks of life:

☐ Apnea	☐ Heart Rhythm Problems	☐ Reduced muscle tone	☐ Transfusions
☐ Difficulty breathing	☐ Increased muscle tone	☐ Reflux	☐ Tube fed
☐ Feeding difficulty	☐ Intracranial bleeding	☐ Scars/bruising	
☐ Head Injury	☐ Jaundice	☐ Seizures	

DEVELOPMENTAL HISTORY

Check the approximate age of your child when he/she developed the following:

Smiled	☐ 0-2 months	☐ 2-4 months	☐ 4-6 months	☐ 6-8 months	☐ 8-12 months
Sat unassisted	☐ 2-4 months	☐ 4-6 months	☐ 6-8 months	☐ 8-10 months	☐ 12-15 months
Simple babbling "baba" or "dada"	☐ 4-6 months	☐ 6-8 months	☐ 8-10 months	☐ 10-12 months	☐ 12-15 months
Complex babbling "babadada" or "mababa"	☐ 6-8 months	☐ 8-10 months	☐ 10-12 months	☐ 12-15 months	☐ More than 15 months
First word	☐ 8-10 months	☐ 10-12 months	☐ 12-14 months	☐ 14-16 months	☐ 16-18 months
Walked	☐ 8-12 months	☐ 12-15 months	☐ 16-18 months	☐ 18-22 months	☐ More than 22 months
Put two words together	☐ 15-18 months	☐ 18-22 months	☐ 22-25 months	☐ 25-30 months	☐ More than 30 months
Short sentences	☐ 18-24 months	☐ 24-30 months	☐ 30-36 months	☐ 36-48 months	☐ 48-60 months

Were there any feeding problems in the early stages? ☐ No ☐ Yes

If yes, please describe: _____

Does your child have a diagnosed hearing loss? ☐ No ☐ Yes

If yes, what is the nature of the hearing loss? _____

Does your child use: Cochlear implant ☐ Hearing aid ☐ FM System ☐

In their: Left ear ☐ Right ear ☐ Both ears ☐

Does your child "get stuck," repeat, or stutter on sounds or words? ☐ No ☐ Yes

If yes, describe what it is like: _____

Does your child's communication seem like other children his/her age? ☐ No ☐ Yes

If no, what makes it different?

☐ Difficult to understand ☐ Seems behind other kids in expressing self ☐ Little eye contact

Other (describe): _____

What efforts does your child make to communicate his/her wants when not understood?: _____

_____

Did speech or language learning ever seem to stop for a period of time? ☐ No ☐ Yes

If yes, please describe: _____

Do you have to frequently repeat instructions?	☐ No	☐ Yes
Does he/she seem to have any difficulty hearing?	☐ No	☐ Yes
Does he/she have any visual problems?	☐ No	☐ Yes
Does he/she wear glasses?	☐ No	☐ Yes

If you checked yes to any if the above, describe your concern: _____

_____

How easily can your child maintain focus during sitting activities (poor, fair, good, or excellent)?

Activity	How Easily?
Listen to a story	
Play video games	
Read/look at pictures	
Watch TV	

EDUCATIONAL HISTORY

Only complete this section if your child is school-age or in day care.

Indicate the type of setting the child spends most of his day:

☐ Day care ☐ Kindergarten ☐ Private School
☐ Home school setting ☐ Preschool ☐ Public School

Name of current school: _____

Grade Level: _____

If your child is school-age, did he/she attend preschool? ☐ No ☐ Yes

Indicate performance level in school:

☐ Above average ☐ Average ☐ Below average

List favorite subjects: _____

_____

List least favorite subjects: _____

Has your child received any special academic tutoring or intervention: ☐ No ☐ Yes

If yes, in what area(s): _____

Provided by: ☐ classroom teacher ☐ teacher specialist ☐ private tutor

Has your child repeated a grade? ☐ No ☐ Yes *If yes, which grade(s)?* _____

If your child is **home-schooled**, please explain why you chose this: _____

_____

If you **home school**, please provide the name of the curriculum used in each area.

Reading: _____

Written Expression: _____

Math: _____

Social Studies/Science: _____

Please indicate any special assistance or services your child receives at school or privately:

Service Provider	**How Often Are Services Provided?**	**What Skills Do They Work On?**
Adaptive PE		
Occupational Therapy		
Physical Therapy		
Psychologist		
Reading Specialist		
Special Education		
Speech-Language Pathology		
Social Work		
Teacher's Aide		
Other:		

Please provide copies of reports from other specialists, including speech-language pathologists who have evaluated and/or treated your child. We would also like to have copies of any evaluations completed at school and your child's current Individualized Education Plan (IEP).