

**University Center for the Development  
of Language and Literacy**

**Children and Adolescent  
Program Application and Case History Form**

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**IDENTIFYING INFORMATION**

Child's name: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_ M \_\_\_\_ F

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

**FAMILY INFORMATION**

Caregiver 1: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

(if different from child's)

\_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_

Education: \_\_\_\_\_

Email: \_\_\_\_\_

Caregiver 2: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

WorkPhone: ( ) \_\_\_\_\_

(if different from child's)

\_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_

Education: \_\_\_\_\_

Email: \_\_\_\_\_

Please list children and adults who live in child's home:

NAME	AGE	RELATIONSHIP

Name of person filling out questionnaire: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Date form completed: \_\_\_\_\_

Has anyone in the family had a history of speech, language or reading difficulties? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please explain: \_\_\_\_\_  
\_\_\_\_\_

I am concerned about my child's:

\_\_\_ understanding of language

\_\_\_ ability to communicate

\_\_\_ speech

\_\_\_ reading

\_\_\_ writing

\_\_\_ spelling

\_\_\_ math

\_\_\_ social interaction

\_\_\_ academic success

**SPEECH, LANGUAGE AND LEARNING INFORMATION**

1. Please describe your concern about your child's language, literacy and/or learning abilities.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. When were the difficulties first noted? \_\_\_\_\_

3. Has the problem \_\_\_\_\_ improved \_\_\_\_\_ worsened \_\_\_\_\_ remained the same? Please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Are there situations in which your child has particular difficulty?

\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

5. Did your child ever acquire speech and then slow down or stop talking? \_\_\_ Yes \_\_\_ No

If yes, how old was s/he? \_\_\_\_\_ Describe: \_\_\_\_\_  
\_\_\_\_\_

6. Is your child bilingual? \_\_\_ Yes \_\_\_ No Other Language: \_\_\_\_\_

What is the primary language used at home? \_\_\_\_\_

7. Which of the following does your child use most frequently to communicate?

\_\_\_\_\_ complete sentences

\_\_\_\_\_ unintelligible speech sounds

\_\_\_\_\_ multiple word phrases, but not sentences

\_\_\_\_\_ gestures

\_\_\_\_\_ single words

\_\_\_\_\_ other \_\_\_\_\_

8. Does your child have difficulty producing specific speech sounds? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, which ones: \_\_\_\_\_

9. How well can your child communicate with:

	<u>Good</u>	<u>Fair</u>	<u>Poor</u>
parents	_____	_____	_____
siblings	_____	_____	_____
strangers	_____	_____	_____
playmates	_____	_____	_____
teachers	_____	_____	_____

10. When you speak to your child s/he seems to understand (check one):

\_\_\_\_\_ everything    \_\_\_\_\_ most everything    \_\_\_\_\_ very little

Explain: \_\_\_\_\_

11. How has your child's language-learning difficulties affected the following?

Social interactions with peers: \_\_\_\_\_

Willingness to talk to others: \_\_\_\_\_

Participation in the classroom: \_\_\_\_\_

Academic success: \_\_\_\_\_

12. Do you feel that your child's self-esteem has been compromised by his/her language learning abilities?

\_\_\_\_\_ Yes    \_\_\_\_\_ No    If yes, please describe: \_\_\_\_\_

13. Has your child's hearing been tested? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please provide date and result of testing: \_\_\_\_\_

14. Are there situations in which your child is successful relative to the areas of concern?

\_\_\_\_\_ Yes    \_\_\_\_\_ No    If yes, please describe: \_\_\_\_\_

1) Please describe what your child does well. \_\_\_\_\_

2) Please describe your child's interests. \_\_\_\_\_

3) Please describe your child's strengths. \_\_\_\_\_

15. Please describe any current related services that your child receives. \_\_\_\_\_

16. Is your child currently enrolled in language therapy? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, has it helped? \_\_\_\_\_

# sessions weekly: \_\_\_\_\_ Length of each session: \_\_\_\_\_

17. Please describe your child's current school placement and services. \_\_\_\_\_

School name: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ Teacher(s)/Program(s): \_\_\_\_\_

18. What is your impression of your child's learning abilities? \_\_\_\_\_

19. How does your child talk about school? Describe \_\_\_\_\_

20. For my child to achieve success and self-confidence, I feel his/her most immediate need is \_\_\_\_\_

21. Is there anything else you feel we should know about your child? \_\_\_\_\_

**MEDICAL AND DEVELOPMENTAL HISTORY**

1. How would you describe your child's health currently?

\_\_\_\_\_ excellent          \_\_\_\_\_ good          \_\_\_\_\_ fair          \_\_\_\_\_ poor\*

\*Explain: \_\_\_\_\_

2. Were there any unusual circumstances during the mother's pregnancy or delivery with this child?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

3. At approximately what age did your child do the following:

\_\_\_\_\_ sit unassisted

\_\_\_\_\_ walk

\_\_\_\_\_ say first word

\_\_\_\_\_ speak in sentences

4. Has your child had any ear infections? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, # of ear infections \_\_\_\_\_ Were tubes used to drain fluid? \_\_\_\_\_ Yes \_\_\_\_\_ No

5. Has your child had any major illnesses? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_

6. Has your child ever had a severe blow to the head (e.g., falling on head, accidentally hit head, etc.)?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, did s/he (check all that apply):

\_\_\_\_\_ lose consciousness \_\_\_\_\_ suffer a concussion \_\_\_\_\_ experience vomiting

7. Please complete the following regarding any medication your child is taking.

Medication	Dosage	Frequency of Administration	Reason for Meds

8. Name of person who referred you to this clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Phone # ( ) \_\_\_\_\_

Profession: \_\_\_\_\_

**PROFESSIONAL SERVICES** (Please provide information on any services that your child has received.)

**Speech & Language Examination/Therapy**

Person/ Agency _____
Address: _____
Dates: _____
Findings: _____
_____

**Reading/Writing Assessment/Services**

Person/ Agency _____
Address: _____
Dates: _____
Findings: _____
_____

**Hearing Testing**

Person/ Agency _____
Address: _____
Dates: _____
Findings: _____
_____

**Psychological Testing / Counseling**

Person/ Agency _____
Address: _____
Dates: _____
Findings: _____
_____

**Behavioral Evaluation / Management**

Person/ Agency _____
Address: _____
Dates: _____
Findings: _____
_____

**FINANCIAL INFORMATION**

Child's Name \_\_\_\_\_

Contact Person \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

- If any portion of the fees are not covered by insurance or funding agencies, will you be able to meet the cost of this program yourself? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If no, have you made application to any organization for help? \_\_\_\_\_ Yes \_\_\_\_\_ No

Name of agency / organization \_\_\_\_\_

Address \_\_\_\_\_

*Street*

*City*

*State*

*Zip*

Person Contacted \_\_\_\_\_ Title \_\_\_\_\_

Phone # ( ) \_\_\_\_\_

**INSURANCE INFORMATION** (You are responsible for any charges not covered by your insurance company.)

Name of **Primary** Insurance \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Subscriber SS #. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer \_\_\_\_\_

Policy/Contract #. \_\_\_\_\_ Group/Control # \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insurance Representative: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_



Name of **Secondary** Insurance \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Subscriber SS. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer \_\_\_\_\_

Policy / Contract # \_\_\_\_\_ Group / Control # \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insurance Representative \_\_\_\_\_ Phone ( ) \_\_\_\_\_



**➤Please attach a photocopy of your Health Insurance Card(s) ◀**

- A letter of medical necessity from your physician is required for billing purposes.
- Written pre-authorization of services must be received from your insurance prior to services.
- Payment is expected at the time services are rendered.
- University Center for the Development of Language and Literacy accepts Visa and MasterCard.

➤University Center for the Development of Language and Literacy is an “Outpatient Speech-Language treatment facility.”◀