EASTERN MICHIGAN UNIVERSITY

Dear Parent or Guardian,

Please fill out the enclosed questionnaire as accurately as possible. The information will help us better prepare for your child's evaluation. Your answers are confidential. They become part of our clinical records, which will only be released with your consent.

Please complete all sections which may apply to your child. If specific dates, illnesses, etc., are unavailable, please so indicate. Please send copies of any previous evaluations (I.E.P), educational services or medical reports.

Also included are a Release of Information form and an Authorization form. The release will allow us to mail your child's reports to you. The Authorization indicates your acceptance that students-in-training will be involved with your child and allows us to make appropriate professional use of the information you have provided.
THESE FORMS MUST BE COMPLETED BEFORE AN APPOINTIMENT CAN BE SCHEDULED.

Please return these completed forms to:

Speech and Hearing Clinic
Suite 135 Porter Building
Eastern Michigan
University Ypsilanti,
Michigan 48197

When we have received all of the completed and signed forms, we will activate file and contact you when we have an opening.

Sincerely,

Speech and Hearing Clinic Staff

EASTERN MICHIGAN UNIVERSITY'S SPEECH AND HEARING CLINIC IS ACCREDITED FOR CLINICAL-SERVICES BY THE COUNCIL FOR PROFESSIONAL SERVICES ACCREDITATION OF THE AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION (ASHA).

Eastern Michigan University

College of Education Clinical Suite

Speech and Hearing Clinic

Suite 135 Porter Building – Ypsilanti, MI 48197 – Phone: (734) 487-4410

I. Identification

Form Completed By	Relationship To Child	Date

Name Of Child	Sex	Age	Birthdate

Address	City	State	Zip

Home Phone	Cell Phone
Email Address	

Immediate Family	Name (Last, First)	Age	Occupation	Education
Mother				
Father				

If The Address Of Either Parent Is Different From Child's, Please Indicate	
Parent	Address
Who Is Responsible For Child?	Relationship

Child's Doctor	
Name	Phone
Address	City
State	Zip

Who Referred You To The Clinic?					
Name		School/Agency			
Address	City		State	Zip	
Phone	Referred For (Place "X" Next To Correct Box)		Speech/Language		Hearing

If Your Child Is Currently Receiving Speech-Language Pathology Services At A Public School, Please List The Following:	
IEP or IFSP	Certification

Category	

II. Statement of Concerns

Describe As Completely As Possible Your Concerns Regarding Your Child's Speech, Language, And/Or Hearing

When Were You First Concerned?

Has Anything Changed Since You Were First Concerned?

What Do You Think Changed Your Concerns?

How Do You And Others In The Family React To Your Child?

What Is Your Child's Reaction To Your Concerns?

What Has Been Done About It? Has It Helped?

III. Speech and Language History

How Much Did Your Child Coo And/Or Babble During The First 6 Months?					
When Did S/He Speak Their First Words?			What Were These First Words?		
How Many Words Did S/He Have At 18 Months?			When Did S/He Begin To Use Two-Word Sentences?		
Does S/He Use Speech (Check One)	Frequently?		Occasionally?		Never?
Did S/He Use Many Gestures?			Give Examples If Possible		
What languages does the child speak?			If the child is bilingual, which language is dominant?		
What language do the parents speak?			What language do the parents speak to the child?		
Which Of The Following Does Your Child Prefer Using? (Check One)					
Complete Sentences		Phrases		One Rr Two Words		Sounds		Gestures
If S/He Makes Sounds Incorrectly, Which Ones?					
If S/He Hesitates, "Gets Stuck", Repeats, Or Stutters On Sounds And/Or Words, Please Describe					

How Does The Child's Voice Sound? (Check All That Apply)								
Normal		Too High		Too Low		Hoarse		Nasal
How Well Can the Child Be Understood By								
Parents?								
Brothers And Sisters?								
Playmates?								
Relatives And Strangers?								
Does S/He Imitate Speech But Not Use It?								
How Well Does S/He Understand What Is Said To Him Or Her?								

If You Think Your Child Does Not Hear Adequately, What do You Feel to Be the Cause?	
Does His or Her Hearing Appear to Be Constant or Does It Vary?	
Is Hearing Poorer When S/He Has A Cold?	

If Your Child Has A Hearing Aid					
In Which Ear(s)?		Make?		Model?	

Does Your Child Currently Respond To (Check All That Apply)							
Door Bell?		Phone?		TV/Radio?		Normal Conversation?	

If The Child Currently Appears To Hear But Not Understand, Describe Common Behaviors

How Does Your Child Communicate At This Time? Provide Examples of His or Her Speech

If Your Child Is Aware Of His Or Her Speech, Language, Or Hearing Problem, Describe Why You Feel This To Be True

If Any Other Family Member Has A Speech, Language, Or Hearing Problem	
Relationship To Child?	
What Is The Problem?	
How Much Contact Does The Child Have With This Person?	

If Your Child Appears To Be Behind His or Her Peers In Any Other Area Other Than Speech, Language, Or Hearing, Please Explain

IV. General Development

A. Pregnancy /Birth History

This Is Our (Check One):	Biological Child		Foster Child		Adopted Child	

Number Of Pregnancies		How Many Miscarriages, Stillbirths?
Explain		
Which Pregnancy Was This Child?	Length Of Pregnancy	Was It Difficult?
Please List Any Illnesses, Diseases, And/Or Accidents Which Occurred During This Pregnancy		

Please List Any Prescription And/Or Non Prescription Medication Taken By Mother During This Pregnancy

Was There A Blood Incompatibility Between The Mother And Father?	
Age Of Mother During Birth	Age Of Father During Birth

If There Were Unusual Problems At Birth (Breech Birth, Cesarean Birth, Others), Please Describe	
Weight Of Child At Birth	Length Of Labor
Drugs Used During Delivery	

Please Describe Any Bruises, Scars, Or Abnormalities Of Your Child's Head
Any Other Abnormalities?
Did Infant Require Oxygen?
Was The Child "Blue" Or Jaundiced At Birth?
Was A Blood Transfusion Required At Birth?

Please Describe Any Problems Immediately Following Birth Or During The First Two Weeks Of Your Infant's Life (Health, Swallowing, Sucking, Feeding, Sleeping, Others)
If Your Infant Lost Weight Following Birth, At What Age Did S/He Regain Birth Weight?

If Mother Was Hospitalized Longer Than Usual, Please Explain Why
If Your Child Was Hospitalized Longer Than Usual, Please Explain Why

B. Developmental History

Was Your Child Breast Or Bottle-Fed?	If Breast Fed, How Long?
Are There Or Have There Been Any Feeding Problems (i.e. Problems With Sucking, Swallowing, Drooling, Chewing, etc.)? If Yes, Please Describe	

At What Age Did The Following Occur?					
Held Head Erect While Lying On Stomach		Walked Unaided		Bowel Trained	
Sat Alone Unsupported		Fed Self With Spoon		Completely Toilet Trained: Walking	
Crawled		Had First Tooth		Completely Toilet Trained: Sleeping	
Stood Alone		Bladder Trained		Dressed And Undressed Self	
Use Single Words (i.e. no, mom)		Combine Words (i.e. me go, daddy shoe)		Name Simple Objects (i.e. Dog, Tree, Car)	
Use Simple Questions (i.e. Where's doggie?)		Engage In A Conversation			

Which Hand Does S/He Prefer?	If Hand Preference, What Age?

How Would You Describe Your Child's Current Physical Development?

C. Medical History

Please Check Any Of The Following Which Your Child Has Experienced Or With Which Your Child Has Been Diagnosed										
Adenoidectomy		Convulsions		Earaches		Heart Problems		Pneumonia		
Allergies		Cross-Eyed		Ear Discharge		Hepatitis		Rheumatic Fever		
Asthma		Croup		Ear Infections		HIV Infection		Scarlet Fever		
Blood Disease		Cytomegalovirus(CMV)		Encephalitis		Mastoidectomy		Tonsillectomy		
Cataracts		Diabetes		Headaches		Nerve Disorder		Vision Problems		
Chickenpox		Diphtheria		Head Injuries		Orthodontia		Whooping Cough		

Is Your Child's Health (√)	If Your Child Is Currently Under Medical Treatment Or On Medication, Please Describe (Name Of Medication, Reason, Dosage, And For How Long Your Child Has Been On It)
Good?	
Fair?	
Poor?	

Has Your Child Ever Fallen Or Had Severe Blow To The Head Which Caused: (Check All That Apply)									
Unconsciousness		Concussion		Nausea		Vomiting		Drowsiness	

Has Your Child Ever Been Hospitalized?		
Where?	How Long?	Physician?

Please List Any Illnesses Which Have Been Accompanied By An Extremely Long, High Fever:

D. Educational History

If Your Child Has Attended The Following, Please Provide The Information Requested Below			
Facility	Age	Frequency	Location
Day Care			
Nursery School			
Kindergarten			

School Attending Now	
Address	

How Does The Child Feel About His Or Her Teachers?

What Has The School Told You About Your Child's Learning Abilities?

What Is Your Impression Of Your Child's Learning Abilities?

Please List And Describe Any Previous Speech, Language, Hearing, Psychological, Or Special Education Evaluations Which S/He Has Received Within The Last 5 Years			
Date	Individual Or Facility	Location	Information You Received

E. Daily Behavior

How Does Your Child Get Along With Other Children?

What Games And Activities Does Your Child Prefer?

How Long Is Your Child's Attention Span?	

How Many Hours Each Day Does Your Child Watch Television?	
Which Program(s) Does Your Child Watch The Most?	

Please Explain Whether Or Not Your Child Will Separate Easily From You For Evaluation And/Or Therapy:

Check The Following As They Apply To Your Child:							
Item	Yes	No	Give Ages (If Possible)	Item	Yes	No	Give Ages (If Possible)
Eating Problems				Shy			
Sleeping Problems				Follows Direction Easily			
Toilet Training Problems				Gets Along With Adults			
Difficulty Concentrating				Emotional			
Needs A Lot Of Discipline				Stays With An Activity			
Underactive				Makes Friends Easily			
Excitable				Happy			
Laughs Easily				Irritable			
Cries Often				Follows Household Routines/Rules			
Difficult To Manage				Accepts Unexpected Changes			
Sensitive				Overactive			

How Often Do You Read To Your Child?

If There Is Any Additional Information You Feel Will Help Us In Understanding Your Child And His Or Her Problems, Please Use The Blank Space Below And The Back Page If Necessary

Name Of Person Completing This Form	Relationship To Client
Date	

EASTERN MICHIGAN UNIVERSITY
COLLEGE OF EDUCATION CLINICAL SUITE
COUNSELING CLINIC ♦♦ READING CLINIC ♦♦ SPEECH AND HEARING CLINIC
Suite 135 Porter Building • Ypsilanti, MI 48197 • phone: (734) 487-4410 • fax: [redacted]

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION FOR _____

I, _____, hereby authorize the College of Education Clinical Suite at Eastern Michigan University to exchange/release information in:

☐ my own record ☐ my spouse's record date of birth _____

☐ my child's record

to the individual or organization listed below, and only under the conditions specified.

1. THE REPORTS WILL BE SENT TO YOU: COMPLETE THE INFORMATION BELOW.

NAME _____

STREET _____

CITY _____ STATE _____ ZIP _____

2. SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED

☐	Diagnosis	☐	Substance use Records	☐	Academic/School Records
☐	Treatment Plan	☐	Ideological Records	☐	Employment Records
☐	Final Report/Treatment Outcome	☐	Evaluation	☐	Court Records
☐	Medical Records and Reports	☐	Psychological Records	☐	Other (please specify below)

3. THE PURPOSE AND NEED FOR SUCH DISCLOSURE

☐	Assessment and treatment planning	☐	Court Ordered	☐	Coordination of treatment
☐	Other				

4. I UNDERSTAND THAT THIS CONSENT CAN BE REVOKED BY ME AT ANY TIME, IN WRITING. UNLESS I CHOOSE TO EXERCISE MY RIGHT OF REVOCATION AT AN EARLIER DATE, THIS CONSENT EXPIRES:

☐	One year from date signed	☐	When requested information has been supplied
☐	At the end of the current academic semester	☐	At termination of treatment
☐	Other (please specify)	☐	

_____ _____

WITNESS **CLIENT/GUARDIAN SIGNATURE**

_____ _____

DATE WITNESSED **DATE SIGNED**

I/ My child attend (s) the: ☐ COUNSELING CLINIC ☐ READING CLINIC ☐ SPEECH AND HEARING

EASTERN MICHIGAN UNIVERSITY
COLLEGE OF EDUCATION CLINICAL SUITE
SPEECH AND HEARING CLINIC

Suite 135 Porter Building • Ypsilanti, MI 48197 • Phone: (734) 487-4410 • Fax: [redacted]

AUTHORIZATION

CLIENT'S NAME		BIRTHDATE	
PARENT'S / GUARDIAN'S NAME		RELATIONSHIP	

PHONE NUMBERS				
PHONE	CLIENT	MOTHER	FATHER	GUARDIAN/SPOUSE
HOME	( )	( )	( )	( )
WORK	( )	( )	( )	( )

PERSON TO BE CONTACTED IN CASE OF EMERGENCY (IF NOT LISTED ABOVE)		
NAME	RELATIONSHIP	PHONE
		( )

I hereby authorize the Eastern Michigan University Speech and Hearing Clinic to make customary and constructive use, exercising due discretion, for education, scientific and professional purposes, and in the public interest of information, photographs, sound recordings, video recordings, and other records and materials pertaining to, and in consideration of, my enrollment, examination, instruction, and scientific participation, or that of my minor child, _____, or that of _____, for whom I am legally responsible, in the Speech and Hearing Clinic. I understand that the services in the clinic are rendered by students as a part of their training program.

_____ _____

Signature Date

*Please note: We do not accept or bill Medicare, Medicaid, nor any other insurance.