Alabama A&M University

Communicative Sciences and Disorders (CSD)

Carver Complex North, Rm 104

Dear Sir/Madam:

Thank you for your interest in choosing Alabama A&M University, *Communicative Sciences and Disorders Clinic* for speech-language services. We are conveniently located on Alabama A&M University's main campus in Carver Complex North, room 104. Attached is the *Client Manual* which has a number of important forms that need to be completed in preparation for the evaluation and remediation process. Please send completed forms to:

Alabama A&M University
Attn: Esther Phillips-Ross
Communicative Sciences and Disorders
PO BOX 357
Normal, AL 35762
esther.phillips@aamu.edu
256-372-4055 (fax)

Completed client forms can also be scanned and or faxed to the clinic via the above email address and fax number. These forms must be received as soon as possible as the AAMU CSD Clinic is a 'free' clinic with a current waiting list. If you have further questions regarding this matter, please feel free to contact me via my direct line-372-4044.

Sincerely,

Esther Phillips-Ross

Esther Phillips-Ross MA,CCC/SLP/L
Assistant Professor/Director of Clinical Services
Communicative Sciences and Disorders Clinic
Alabama A&M University

ALABAMA A & M UNIVERSITY
Communicative Sciences & Disorders Clinic (CSD)
(Carver Complex North 104)

CLIENT HANDBOOK

2019-2020

We are proud to be an ASHA-Accredited Program!

We are accredited by the Council for Academic Accreditation (CAA) in Audiology and Speech-Language Pathology of the American Speech-Language-Hearing Association (ASHA).

To Contact ASHA:
2200 Research Boulevard
Rockville, MD 20850

***1-800-498-2071 or** http://www.asha.org*

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CSD CLINICAL FACULTY/STAFF

Ms. Nelka Ortega Cotto (Nicky), AAMU CSD and Clinic Secretary
372-5541
Mrs. Esther Phillips-Ross, Assistant Professor, **Director of Clinical Services**
M.A., CCC-SLP/L
372-4044
Mrs. Jennifer Horne, Assistant Professor, **Clinical Supervisor**
M.S. CCC-SLP/L
372-4035
Dr. Hope Reed, Associate Professor, **Orofacial Myologist**
CCC-SLP-D
372-4036
Dr. Carol Deakin, Associate Professor, **Clinical Supervisor, TBI Specialist**
Ph.D, CCC-SLP/L
372-4043
Dr. Diana Blakney-Billings, Associate Professor, **Audiologist, Audiology Clinic**
Au.D,CCC-A
372-5541

STATEMENT OF PURPOSE

Alabama A&M University Communicative Sciences and Disorders (CSD) Clinic is a training clinic that is currently free to the public. Our clinic provides hands-on training for graduate and undergraduate students as they progress through the CSD program, learning to apply information gained in the classroom. All students are supervised by ASHA-certified (national) and ABESPA licensed faculty. As AAMU CSD student-clinicians develop clinical skills, they are placed in a position to serve the speech-, language-, and hearing needs of individuals in our community and enhance the effectiveness and quality of communication.

SHARED COMMITMENTS

AAMU CSD Program/Clinic will . . .

1. Prepare quality professionals who will be employed in both the public and private sectors (e.g., hospitals, schools, nursing homes) emphasizing transdisciplinary experiences with physicians, nurses, social workers, case managers, teachers, psychologists, and other specialists in health care fields,
2. Provide quality speech-, language-, and hearing clinical services to clients at Alabama A & M University and its surrounding communities,
3. Disseminate information regarding speech, language, and hearing behaviors through research and collaborative scholarly activities (e.g., presentations, consultations, and publications), and
4. Provide community service programs focusing on awareness, education, and prevention of speech-, language-, and hearing disorders.

CLINICAL SERVICES

Clinical services are provided by both undergraduate and graduate students in the Communicative Sciences and Disorders program while being supervised by nationally certified clinical faculty. (i.e., faculty who hold the Certificate of Clinical Competency from ASHA).

Specific services offered by the *Alabama A & M University Communicative Sciences and Disorders (CSD) Clinic* include the diagnostic evaluation and remediation/treatment of speech-language-, and hearing disorders. Prior to enrollment in any of the therapy programs, a current speech and language evaluation must be completed, as well as a hearing screening. Clients with vocal/voice concerns may be required to have a physician's written referral. If a prior evaluation has been completed by another speech-language pathologist/audiologist, the client or guardian may request that the evaluation records be released to AAMU CSD Clinic. However, an evaluation will be administered for all new and returning clients. In addition, each client, (or guardian), must complete and sign the appropriate forms, which include:

1. Case history form,
2. Authorization for video/audio taping, and student observations and chart review for educational purposes,
3. Authorization for release of information TO another agency or physician (if applicable), and
4. Authorization for release of information FROM another agency or physician (if applicable).
5. Consent for Clinical Services form

Therapy will not be initiated until these forms have been completed and received. These forms can be located on-line under "client forms and manuals", at http://www.aamu.edu/csd/csdclinic.aspx and in appendix A of this document.

EVALUATION

The evaluation of the client's communication skills addresses . . .

1. The ability to understand and produce language—may include literacy components,
2. The ability to produce speech sounds,
3. Voice characteristics,
4. Speech fluency,
5. Oral-motor structures and functions, and
6. Auditory (hearing) skills.

Following the evaluation, recommendations may include enrollment for therapy, referral to another professional agency, or a re-evaluation at a later date.

SERVICE PROVISION POLICIES

Services are provided to clients of all ages. No client will be refused services on the basis of race, gender, ethnic origin, or religion. This policy is in compliance with Title VI of the Civil Rights Act of 1964 and other current regulations that safeguard against discrimination. The Alabama A & M University CSD Clinic reserves the right to refuse services to clients who may be considered inappropriate candidates in this clinical setting.

The Alabama A & M University Communicative Sciences and Disorders Clinic serves the educational and training needs of students. In order for the student clinicians to better

understand the nature of a client's communication disorder, digital recordings may be performed. These media are considered confidential and are solely for the purpose of education. They will be used only by student clinicians, clinical faculty, and clients. The client or guardian must sign an *Authorization for video/audio taping for educational purposes* form to allow these services to be performed. Occasionally, clients may be requested to participate in ongoing research. Such participation is formally requested, and proceeds only with the client's or guardian's consent.

CONFERENCES

Conferences with the family will be scheduled periodically. These conferences usually take place at the beginning and end of the semester. However, a client or family may request a conference at any time by contacting the client's faculty clinical supervisor.

PERIODIC RE-EVALUATIONS

Periodic re-evaluations will be performed throughout the therapy process to continually assess speech-, language-, and hearing skills. This allows for assessment of progress and the planning and development of future therapy goals.

OBSERVATION

Observation of diagnostic and therapy procedures is available to the client's family members in the AAMU CSD observation suites. To prevent client distraction, it is preferred that the family does not sit in the therapy room during a diagnostic or therapy session. In this educational/training environment, sessions may be observed by other students in training. All observers will be required to sign a *Confidentiality Statement* to satisfy state HIPAA requirements.

CONFIDENTIALITY OF RECORDS

A clinic/working folder is maintained for all clients seen at the Alabama A & M University CSD Clinic. Included in this folder are diagnostic findings/reports, therapy reports, case history information, consent forms, as well as other pertinent information. This information is considered confidential. Access to the folder is granted to client's family members, supervising faculty, and student clinicians working directly with the client.

When specifically requested in writing per designated clinic form (one form per request), the clinic will supply relevant information to specified entities such as physicians, schools, or other professionals.

A permanent record is kept for each client of activities in this clinic. No information which could potentially identify the client leaves the clinic. All such information is carefully guarded within the clinic. For more details, contact your faculty supervisor.

WAITING ROOM

The waiting room is for families of the clients enrolled in clinical services. Donations of books, magazines, and toys are greatly appreciated. Parents are asked to please keep the waiting

area clean by returning items to designated areas/places when leaving the clinic. Children are to be supervised at all times. The AAMU CSD Clinic is a "No Smoking/Vaping" zone.

ATTENDANCE

Most clients are seen twice per week for 50-minute sessions. Therapy is most effective when attendance is regular. It is important that every effort be made to be present for ALL scheduled therapy sessions and to arrive on time. THREE absences in a semester or TWO consecutive absences could result in dismissal from therapy for the remainder of the semester. Extenuating circumstances may allow for exceptions at the discretion of the supervisor.

Upon dismissal from the program for absences, the client will be expected to call to request being placed back on the waiting list for the following semester. We begin taking clients for the upcoming semester approximately 1 month before the close of the current semester.

Fall semester – call in July
Spring semester – call in November
Summer semester – call in April

If you must be absent for any reason, please contact the clinical supervisor(s) -- Mrs. Phillips-Ross, 372-4044; Mrs. Jennifer Horne, 372-4035; or The clinic secretary, Nicky Cotto, 372-5541--as soon as you know that you will not be able to attend. If the above individuals are unavailable, please leave a voice mail message.

CLINIC FEES

The AAMU CSD Clinic is a free clinic. Clients selected to receive services clients will be notified. It will be important for all clients to attend clinic sessions on a regular schedule (void of non-emergency absences) to avoid being placed on the waiting list as outlined in this Client Handbook. Clients may be asked to pay for specialized equipment and devices used specifically for their specified communication needs.

GRIEVANCE PROCEDURE AND POLICY

The clinical faculty welcomes any comments or suggestions that may prove beneficial to the client during the diagnostic or therapy process. Complaints related to clinical services should be directed to the Clinic Director, Mrs. Phillips-Ross.

PARKING

All clients are required to request an CSD Clinic Parking Pass from the secretary, Nicky, during the first week of service. All clients must display the parking pass in the windshield or rearview mirror of their vehicle. The parking pass will expire at the end of each semester. New parking passes are issued in the beginning of each semester. Clients are permitted to park in the lots adjacent to either clinic (CCN, CCE, and CCS). Parking is permitted in spaces designated for CSD Patient Parking and in UN-NUMBERED faculty/staff parking spaces ONLY.

TRANSPORTATION

Clients needing transportation to the AAMU CSD Clinic may make arrangements through Handi Ride. There is an application process/fee and not all applicants will qualify. If you desire to inquire about the services Handi Ride provides, they may be contacted at 256-427-6857 (scheduling) or 256-532-RIDE

POLICY FOR CLIENT/CLINIC SAFETY/GUARDIANSHIP

To ensure the safety, security, and well-being of clients served in the AAMU CSD Clinic, guardians of minor children and medical guardians of adults must sign a 'consent to treat form' on behalf of the client, before services are rendered. All clients will be accompanied to and from therapy sessions by their assigned student clinician or supervisor. Specifically, upon completion of therapy sessions, clients are to be escorted to the lobby or other waiting areas and/or returned to the care of their responsible party, unless the client is able to legally operate independently (i.e. drive/UBER/bus and attend therapy appointments independently). Medical guardians of unaccompanied adult clients, upon signing the *Consent to Treat* form, waive all liabilities if such clients leave the AAMU CSD Clinic voluntarily. The AAMU CSD Clinic will attempt to contact the guardian if the latter occurs.

In the event that a client's safety is in question, The AAMU CSD Clinic reserves the right to request that a caregiver accompanies the client to services and remain on AAMU CSD Clinic premises while the client receives services. If the CSD Clinic faculty/staff feel that a client's safety may be in jeopardy, the following actions should be taken:

- Notify AAMU Police Department/Public Safety of the current situation (5555)
- Alert Clinical Director/Clinical Supervisors to assist with the situation (4044/4035)
- Alert the client's responsible party
- Complete a formal incident report

POLICY FOR COMMUNICABLE DISEASES

In the attempt to control the transmission of the communicable diseases listed below, the following policy will be adhered to in the Alabama A&M CSD Clinic:

DISEASE	**MINIMUM PERIOD OF ISOLATION OF THE CHILD**
Chicken Pox (varicella)	Individual must remain at home until all lesions are crusted and dry. Susceptible child exposed to chicken pox will be excluded from the 10th through the 21st day after exposure. Anyone who has received V12G will be excluded for 28 days.
Conjunctivitis (Pinkeye)	Individual must remain home until 24 hours after treatment (antibiotic eye drops) is initiated.
German Measles	Individual must remain at home for at least five (5) days after onset of rash. Susceptible child will be excluded from the 7th to the 21st day after exposure.
Impetigo	Individual must remain at home until 24 hours after treatment is initiated.
Influenza	Individual must remain home until no fever is detected for 24 hours.
Lice (Pediculosis)	Individual must remain at home until the morning after treatment.

Measles (Rubella)	Individual must remain at home for four (4) days after the appearance of rash. Susceptible child will be excluded from the 5th exposure.
Mumps	Individual must remain at home for nine (9) days after onset of swelling. Susceptible person will be excluded from the 12th to the 26th day after exposure.
Scabies	Individual must remain at home until treatment has been completed.
Streptococcus (strep)	Individual must remain home until 24 hours after the first dose of antibiotics is given and be free of fever.
REFERENCE:	Isolation and Quarantine Regulations

Published by the Massachusetts Department of Public Health, Division of Communicable Disease, March, 1992. Report of the Committee on Infectious Diseases, American Academy of Pediatrics, 1991; Kidshealth, 2002; State of New york Department of Heath, 2008.

We wish you the best possible success here in the clinic. Together, we can make a difference!

Alabama A&M University
Communicative Sciences and Disorders
PROGRAM

CONFIDENTIALITY STATEMENT
Client Handbook

I understand that information regarding clients and or students in the CSD Program, (including anything observed in the clinic, and information heard re: other families, clients, faculty, staff or student clinicians) is to be held strictly confidential.

_____	_____	_____
Printed Name	Signature	Today's Date

****Please sign and submit this document to the Program Secretary, during initial visit to the clinic.*

APPENDIX A

AAMU CSD CLIENT CLINIC FORMS

1. Child Case History Form
2. Adult Case History Form
3. Attendance Contract
4. Consent for Clinical Services
5. Authorization form Release of Information to Another Agency or Physician
6. Authorization form Release of information from Another Agency or Physician
7. Authorization form Video/Digital Recording for Educational Purposes

Alabama A & M University
Communicative Sciences and Disorders Clinic
P.O. Box 357
Normal, Alabama 35762
Phone: (256)372-5541 or (256)372-4044

CASE HISTORY FORM – CHILD

IDENTIFYING INFORMATION/SOCIAL/EDUCATONAL HISTORY

Child's Name _____ Sex _____

Birthdate _____ Age _____ Today's Date _____

Name by which your child is called _____ Handedness Right Left **(circle)**

Address: _____ Home Phone _____

City _____ State _____ Zip _____ Cell phone _____

Guardian/Parents: Name Age Occupation Education Work #

Father_____ ____ _____ _____ _____

Mother _____ ____ _____ _____ _____

Guardian_____ ____ _____ _____ _____

If address of either parent/guardian is different from that of child, please indicate:

Email Address: _____

*Primary language spoken in the home? _____

Is the child adopted? _____ yes _____ no If so, at what age? _____

List children, in order of birth:

Name	Sex	Age	Grade/School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do any siblings have any speech or language difficulties? ❑ yes ❑ no
Specify _____

Who referred you to the AAMU Speech and Hearing Clinic? _____

Address (if professional) _____

Child's Doctor: Name _____

Address of Dr. _____
Do you want a copy of our report(s) sent to your child's doctor? ❑ yes ❑ no

To what other professional person(s) or agency (ies) do you want a report sent? Please include names of professionals and addresses: _____

COMMUNICATON/MEDICAL HISTORY
STATEMENT OF THE PROBLEM

Describe in your own words what problem(s) the child/minor is/are having with speech, language, and/or hearing.
_____

Why do you want your child evaluated by the AAMU Speech and Hearing Clinic? _____

When the problem was first noticed? _____

Who first noticed the problem? _____

What reactions does the child, parent, siblings, relatives, and/or friends have towards the problem? _____

What things have been utilized to aid your child's speech? _____

_____

If the child's speech varies, under what circumstances does it become:

Better: _____

Worse: _____

Have professional advice been sought about your child's speech, language, and/or hearing problem before?

Evaluation _____ Therapy _____ When? _____

Whom did you see? _____

Length of therapy _____

Results _____

What recommendations were made? _____

What has been done since then? _____

How does your child feel about his/her speaking ability? _____

Has your child ever been diagnosed as a "poor reader"? ❑ yes ❑no

By whom was the diagnosis made? _____

Check the items that your child seems to do more than other children the same age:

_____ 1. Avoids speaking at school.
_____ 2. Avoids speaking in play situations.
_____ 3. Avoids speaking at home.
_____ 4. Avoids speaking to children (male _____, female _____).
_____ 5. Avoids speaking to adults (male _____, female _____).
_____ 6. Avoids saying certain words. (List _____)
_____ 7. Cries when unable to communicate.
_____ 8. Becomes aggressive when unable to communicate.

GENERAL DEVELOPMENTAL HISTORY

Was this your first pregnancy? ❑ yes ❑ no
If not, how many pregnancies have you had? _____ Which pregnancy was this child? _____
Any medical problems prior to this pregnancy? ❑ yes ❑ no
If so, please describe: _____
Did you have an illness during pregnancy? ❑yes ❑ no
If so, please explain: _____
Did you have to take medication during pregnancy? ❑ yes ❑ no
If so, what medications? _____
Did your baby come more than two weeks early? ❑ yes ❑ no
Did your baby come more than two weeks late? ❑ yes ❑ no
Was labor longer than 24 hours? ❑ yes ❑ no
Was the birth by Cesarean? ❑ yes ❑no
Were forceps used during the birth? ❑ yes ❑ no
Birth weight _____ pounds, _____ ounces
Did your baby have trouble in the hospital? ❑ yes ❑ no
_____ blue spell _____ yellow jaundice _____ breathing problems
_____ required oxygen _____ infection diagnosed _____ required transfusion
Other: _____
How long were mother and child in the hospital? _____
Physician's Name _____ Hospital _____

Did you bottle feed your baby? ❑ yes ❑ no
Did your baby cry more than average? ❑ yes ❑ no
Did your baby spit a lot? ❑yes ❑ no
Did your baby have any feeding problems? ❑ yes ❑ no
Did your baby have nasal stuffiness? ❑ yes ❑ no
Did your baby have rattling when breathing? ❑ yes ❑ no
Did your have any major concerns in the first three months of your baby's life? ❑ yes ❑ no

Give ages at which the following first occurred:
Held head up _____ Crawled _____ Reached for objects _____
Stood _____ Walked unaided _____ Ran _____
First tooth _____ Bladder trained _____ Bowel trained _____

SPEECH AND LANGUAGE DEVELOPMENT

Did your child make babbling or cooing sounds during the first 6 months? ❑yes ❑no

At what age did your child say his/her first word? _____

What were the child's first words? _____

Did your child keep adding words once he/she started talking? ❑ yes ❑ no

At what age did your child begin using 2- and 3-word sentences? _____
Examples _____

Does your child talk frequently? _____ occasionally? _____ never? _____
Does your child prefer to talk? _____ gesture? _____ both talk and gesture? _____
Does your child most frequently use sounds? _____ single words _____ 2-word sentences _____
3-word sentences _____ more than 3-word sentences _____

Does your child make sounds incorrectly? ❑yes ❑no
If so, which ones? _____

Does your child hesitate, "get stuck", or repeat or stutter on sounds or words? ❑ yes ❑ no
If so, describe. _____

Describe any recent changes in your child's speech: _____

Can your child say a nursery rhyme? ❑ yes ❑ no
Can your child tell a simple story? ❑ yes ❑ no
How well can your child be understand by his/her parents? _____
Siblings? _____ Friends? _____
Relatives? _____ Strangers? _____

Does your child understand what you say to him/her? ❑ yes ❑ no
Can he/she follow simple commands? ❑ yes ❑ no
Will he/she get common objects when asked to do so? ❑ yes ❑ no
Does your child have trouble remembering what you have told him/her? ❑yes ❑no
If so, when does this seem to happen? _____
Does your child use any books or games? ❑ yes ❑no
How often do you read to your child? _____

BEHAVIORAL INFORMATION

Check these as they apply to your child:

	Yes	No	Explain: give ages, if possible
Eating problems			
Sleeping problems			
Ear infections			
Toilet training problems			
Difficulty concentrating			
Needed a lot of discipline			
Underactive			
Excitable			
Laughs easily			
Cried a lot			
Difficult to manage			
Overactive			
Sensitive			
Personality problem			
Gets along with children			
Gets along with adults			
Emotional			
Stays with an activity			
Makes friends easily			
Happy			
Irritable			
Prefers to play alone			

Describe any other type of behavior you consider to be a problem: _____
_____
_____
*Describe and indicate prescribed and over-the-counter medications taken by the client.
_____

EDUCATIONAL HISTORY

Does your child perform ❑average ❑below average or ❑above average on work in school?
What are your child's best subjects? _____
What are your child's poorest subjects? _____
Does your child receive any special assistance or help at school? ❑ yes ❑ no
If so, describe: _____
Has he/she repeated a grade? ❑yes ❑ no
If so, which one(s)? _____
What is your impression of your child's learning abilities? _____

Describe any speech, language, hearing, psychological, and special education services that have been performed, including where this was done. Include how often your child was seen in this service. _____

MEDICAL HISTORY: DESCRIBE YOUR PRESENT HEALTH

List periods of hospitalization or medical treatment/surgeries within the last 5 years:

Hospital/City/State	Dates	Reason

List all prescription and nonprescription medication currently used.

Has your child had a neurological examination? ? If so, by whom, when, and where?

Is there a medical history of:

	Yes	No		Yes	No
Allergies	❑	❑	Heart trouble	❑	❑
Sinus infections	❑	❑	Numbness	❑	❑
Anemia	❑	❑	Paralysis//paresis	❑	❑
Asthma	❑	❑	Incoordination of face or tongue	❑	❑
Broken nose	❑	❑	Influenza	❑	❑
Bronchitis	❑	❑	Mouth-breathing	❑	❑
Chronic colds	❑	❑	Mumps	❑	❑
Chronic laryngitis	❑	❑	Pneumonia	❑	❑
Chronic ear infections	❑	❑	Tuberculosis	❑	❑
Cleft palate	❑	❑	Poliomyelitis	❑	❑
Diabetes	❑	❑	Seizures	❑	❑

Hypertension	❑	❑	Head Injury	❑	❑
CVA/Stroke	❑	❑	Neurological Conditions	❑	❑
Chronic Laryngitis	❑	❑	Cancer	❑	❑
Pneumonia	❑	❑	Cerebral Palsy	❑	❑
Thyroid Issues	❑	❑	Intellectual deficits	❑	❑
Facial Nerve Palsy	❑	❑	Emotional/Psychological Issues	❑	❑
Multiple Sclerosis	❑	❑	Huntington's/Parkinson's	❑	❑
Voice Issues	❑	❑	Vocal Polyps or Nodules	❑	❑
Acid Reflux	❑	❑	Psychological counseling	❑	❑
Diphtheria	❑	❑	Rheumatic fever	❑	❑
Ear Infection	❑	❑	Scarlet fever	❑	❑
Glandular imbalance	❑	❑	Tremor/twitching	❑	❑
Hearing problem	❑	❑	Ulcers	❑	❑
Hearing aid	❑	❑	Visual problems	❑	❑
Hormone therapy	❑	❑	Glasses	❑	❑
Hyperthyroidism	❑	❑	Other	❑	❑
Emotional difficulty	❑	❑			

If the answer to any of the above items is "yes", give the relevant details (e.g., how frequent are these episodes, how severe are these episodes, etc.)

_____

_____

_____

OTHER

What games and toys does your child prefer? _____

_____

_____

_____

How many hours each day does your child watch television? _____
Which programs does he/she watch? _____
_____
_____

Please list what you would consider your child's favorite food(s) and snack food(s). _____
_____

To what things/food(s) are your child allergic?
_____

What may we use for reinforcement for your child (i.e., candy, raisins, stickers, etc.)? _____
_____
_____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to client _____

Address _____ Home phone _____

City _____ State _____ Zip _____ Cell phone _____

Alabama A & M University
Communicative Sciences and Disorders Clinic
P.O. Box 357
Normal, Alabama 35762
Phone: (256) 372-5541 or (256) 372-4044
Fax: (256) 372-4055

CASE HISTORY FORM – ADULT

IDENTIFYING INFORMATION/SOCIAL/EDUCATIONAL HISTORY

Name _____ Sex _____ Marital Status _____

Birthdate _____ Age _____ Today's Date _____ Handedness Right Left (circle)

Address: _____ Home Phone _____

City _____ State _____ Zip _____ Cell phone _____

Email Address:_____

Name of Guardian _____ Relationship _____
Proof of Guardianship required
Address: _____ Home Phone _____

City _____ State _____ Zip _____ Cell phone _____

Date of Guardianship:_____

Email Address:_____

Name of alternate contact person _____ Relationship _____

Address: _____ Home Phone _____

City _____ State _____ Zip _____ Cell phone _____

Place of Employment or Previous Employment
Address: _____ Home Phone _____

City _____ State _____ Zip _____ Cell phone _____

Who referred you to the AAMU Speech and Hearing Clinic? _____

Address (if professional) _____

Doctor _____

Address of Dr. _____

Do you want a copy of our report(s) sent to your doctor? ❑Yes ❑No

To what professional person(s) or agency(ies) do you want a report sent? Please include names of professionals and addresses: _____

_____

Primary language spoken in the home: _____

If you speak a language other than English, please state the language _____

List names and ages of person(s) in your home:

Name	Age	Relationship

EDUCATION

School	Location	Highest Grad or Degree Completed	Date

MEDICAL HISTORY: DESCRIBE YOUR PRESENT HEALTH

List periods of hospitalization or medical treatment/surgeries within the last 5 years:

Hospital/City/State	Dates	Reason

List all prescription and nonprescription medication currently used.

_____

_____

Have you had a neurological examination? If so, by whom, when, and where?

_____

_____

Do you use any of the following assistance devices?

❑Wheelchair ❑Walker ❑Cane ❑Other ❑None

Are you able to climb stairs: ❑Yes ❑No

Is there a medical history of:

	Yes	No		Yes	No
Allergies	❑	❑	Heart trouble	❑	❑
Sinus infections	❑	❑	Numbness	❑	❑
Anemia	❑	❑	Paralysis//paresis	❑	❑
Asthma	❑	❑	Incoordination of face or tongue	❑	❑
Broken nose	❑	❑	Influenza	❑	❑
Bronchitis	❑	❑	Mouth-breathing	❑	❑
Chronic colds	❑	❑	Mumps	❑	❑
Chronic laryngitis	❑	❑	Pneumonia	❑	❑
Chronic ear infections	❑	❑	Tuberculosis	❑	❑
Cleft palate	❑	❑	Poliomyelitis	❑	❑
Diabetes	❑	❑	Seizures	❑	❑
Hypertension	❑	❑	Head Injury	❑	❑
CVA/Stroke	❑	❑	Neurological Conditions	❑	❑
Chronic Laryngitis	❑	❑	Cancer	❑	❑
Pneumonia	❑	❑	Cerebral Palsy	❑	❑
Thyroid Issues	❑	❑	Intellectual deficits	❑	❑
Facial Nerve Palsy	❑	❑	Emotional/Psychological Issues	❑	❑
Multiple Sclerosis	❑	❑	Huntington's/Parkinson's	❑	❑
Voice Issues	❑	❑	Vocal Polyps or Nodules	❑	❑
Acid Reflux	❑	❑	Psychological counseling	❑	❑
Diphtheria	❑	❑	Rheumatic fever	❑	❑
Ear Infection	❑	❑	Scarlet fever	❑	❑
Glandular imbalance	❑	❑	Tremor/twitching	❑	❑
Hearing problem	❑	❑	Ulcers	❑	❑
Hearing aid	❑	❑	Visual problems	❑	❑
Hormone therapy	❑	❑	Glasses	❑	❑
Hyperthyroidism	❑	❑	Other	❑	❑
Emotional difficulty	❑	❑			
Smoking	❑	❑	Amount Per Day?	_____	
Drinking	❑	❑	Amount Per Day?	_____	

If the answer to any of the above items is "yes", give the relevant details (e.g., how frequent are these episodes, how severe are these episodes, etc.)

_____

_____

_____

What is your current state of Health? ❑Excellent ❑Average-fair ❑Poor

SPEECH-LANGUAGE HISTORY

Symptom	Never	Sometimes	Frequently
Difficulty expressing thoughts			
Difficulty being understood by others			
Difficulty understanding what others are saying to you			
Orientation/memory			
Problem solving			
Focusing/attention			
Reading/writing			
Finding words			
Maintaining topic of conversation			
Fluent speech (stuttering)			
Following directions			
Oral motor weakness (weakness, difficulty coordinating tongue, cheeks, lips, etc.)			
Voice difficulties			
Difficulty swallowing			

Please describe in your own words the nature of your communication concern(s).

_____

_____

What do you think caused the problem? _____

When did you first notice the problem? _____

What were the circumstances? _____

Have any members of your immediate family have hearing or speech problems? _____

Describe the problem? _____

_____

How do you feel your communication problem has affected your occupation/social life?

_____

_____

_____

In your opinion, If you didn't have a communication problem, how would your life be different?

_____

_____

Describe the reaction of people, including your immediate family, to your communication problem.

List any specific communication situations that present difficulty for you.

List any specific communication situations that you avoid.

List interests you have or activities you engage in (clubs, hobbies, organizations, etc.)

What, if anything, have you tried to do to correct your communication problem?

Are you coming to AAMU Speech and Hearing Clinic on your own? _____ Or by the advice of another person? _____

Have you ever received any prior speech, language, or hearing evaluations? Therapy? _____

If so where?

Agency _____ Agency _____

Address _____ Address _____

Dates _____ Dates _____

Results _____ Results _____

Did prior evaluation or therapy relate to the present problem? _____

How effective has prior therapy been in helping with your problem (What helped the most? least?)

Why was therapy terminated? _____

Has the nature of the problem changed any time? _____

Explain _____

List any additional information that may be helpful to us in assisting you with your problem(s).

Allergies, etc.

Alabama A&M University

Communicative Sciences and Disorders Clinic

Attendance Contract

Client's Name: _____

I,_____have read the *AAMU CSD Client Handbook* and I
(Name of guardian if client is a minor)
agree to attend each service session consistently (aside when ill or in the case of a family emergency). I agree to attend the sessions on time. I am aware that if I am absent for more than three sessions, I may be placed on the waiting list for the following semester. I am aware of and agree to abide by the rules and regulations developed by and set forth by the AAMU CSD Clinic while an active client receiving services.

Date of Contract: _____ Client/Guardian Signature: _____
(Signature of guardian required if client is under 18 years)

Clinical Director: _____
Esther J.Phillips- Ross MA, CCC/SLP/L

Consent for Clinical Services
Communicative Sciences and Disorders Clinic
CARVER COMPLEX RM 104

I,_____(self/guardian), hereby give the Alabama A&M University CSD Clinic permission to screen, evaluate and treat:

❑Self
❑Minor/ward(s), _____, _____, _____
Name(s)
for speech, language, literacy and hearing concerns.

For AAMU CDC Clients Only:
I understand that the Alabama A&M University Child Development Center/Lab has referred my child(ren) to the AAMU CSD Clinic for assessment purposes. If in the event speech, language, literacy treatment is warranted, I hereby grant permission for my minor/child(ren) to receive these services at the AAMU CSD Clinic.

For AAMU Adult Clients with Guardians Only:
Medical/full guardians of unaccompanied adult clients, upon signing the *Consent for Clinical Services* form, waive all liabilities if such clients leave the AAMU CSD Clinic voluntarily. The AAMU CSD Clinic will attempt to contact the guardian if such an event occurs.

The following individual(s) is/are permitted to know about services rendered on my (minor/ward) behalf:

_____	_____
Name	Relation
_____	_____
Name	Relation

_____
Self/Guardian Signature Date

Alabama A&M University

Communicative Sciences and Disorders Clinic

AUTHORIZATION FOR RELEASE OF INFORMATION

TO ANOTHER AGENCY OR PHYSICIAN

Client's Full Name: _____ Birthdate: _____

I ,_____hereby consent the release of any or all hearing, speech,
(Name of guardian if client is a minor)
and language records concerning the above-named individual to:

Name/Agency: _____

Address: _____

_____

_____

Client/Guardian Signature: _____ Date: _____
(Signature of guardian required if client is under 18 years)

Updated 7/27/2017

Alabama A&M University

Communicative Sciences and Disorders Clinic

AUTHORIZATION FOR RELEASE OF INFORMATION FROM ANOTHER AGENCY OR PHYSICIAN

The person named below has requested services from our facility, *Alabama A & M University Communicative Sciences and Disorders (CSD) Clinic*. We understand that this individual has received professional services from you. Kindly forward any hearing, speech, language, medical, psychological, educational, or social records regarding this individual to aid us in better serving this client. Below is written authorization for the release of these records. Please send this information to the following:

Alabama A & M University CSD Clinic
Attention: Mrs. Esther Phillips-Ross, Director of Clinical Services
P O Box 357
Normal, AL 35762
esther.ross@aamu.edu

Thank you for you cooperation.

This will certify that you have my permission to release information to *Alabama A & M Communicative Sciences and Disorders Clinic* concerning:

_____
(Client's full name)

Name of guardian authorizing release:_____
(Print full name)

Client/Guardian Signature: _____ Date: _____
(Signature of guardian required if client is under 18 years)

Updated 7/14/2014

Alabama A&M University

Communicative Sciences and Disorders Clinic

AUTHORIZATION FOR OBSERVATION/DIGITAL RECORDINGS/ PHOTOGRAPHS FOR EDUCATIONAL PURPOSES

Client's Full Name: _____ Birthdate: _____

I understand that the Alabama A & M University Communicative Sciences and Disorders Clinic is housed in an educational environment. I hereby consent to the following for teaching purposes only:

- ❑ Live Observation
- ❑ Video/Digital Recording
- ❑ Still/Live photographs

I require the following exception(s): _____

Client/Guardian Signature: _____
(Signature of guardian required if client is under 18 years)

Relationship to Client: _____

Witness: _____

Date: _____

Updated 7/27/2017

Alabama A & M University

Speech-Language-Hearing Clinic
REQUEST FOR CLINICAL SERVICES
*SUMMER 2019

Client's Name: _____ DOB: _____ Age: _____

Spouse's/Parent's Name, if applicable: _____

Email address:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: home _____ work _____ other _____

Please circle/check the following information:

- Number of days per week you would prefer: 1 or 2
- Prefer: Individual Therapy or Group Therapy
- Preferred day(s) and time: Select BOTH preferred option and secondary option

Preferred Option

❒Tuesday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm

❒Thursday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm

Secondary Option

❒Tuesday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm

❒Thursday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm

____ I do not know my schedule for Summer '19 (ONLY for clients who are AAMU students).

We will **attempt** to accommodate your preferred and secondary options. Please return these forms to your current student clinician as soon as possible, with a current email address as we will be sending updates re: clinical service via this venue. **We MUST have these forms back to include you on the list for the coming semester by April 29th**.

The Clinic is tentatively scheduled to open June 18th thru July 18th. Please make every effort to attend all therapy sessions to get the maximum benefit of therapy. Also be aware that attendance will be taken into consideration when scheduling for future semesters.

A graduate clinician will be contacting you to confirm therapy times for Summer '19 during the last week in May/first week in June. If you have any questions or concerns, please call or leave a voice mail message at 372-4044/5541. Please feel free to write additional information that we should consider when scheduling, on the back of this form. Thank you for your continued support of our clinic. We look forward to working with you again.

Sincerely,

Mrs. Esther-Phillips-Ross

Mrs. Esther Phillips-Ross MA, CCC/SLP/L
Clinic Director
esther.ross@aamu.edu
AAMU Communicative Sciences and Disorders Clinic

For Clinic Use Only: Dx _____ Tx _____ Case Hx _____ Referral _____
Comments:

Alabama A & M University

Speech-Language-Hearing Clinic
REQUEST FOR CLINICAL SERVICES
FALL 2019

Client's Name: _____ **DOB:** _____ **Age:** _____

Spouse's/Parent's Name, if applicable: _____

Email address: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: home _____ work _____ other _____

Please circle/check the following information:

- Number of days per week you would prefer: 1 or 2
- Prefer: Individual Therapy or Group Therapy
- Preferred day(s) and time: Select BOTH preferred option and secondary option

Preferred Option

❒Monday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm
❒4:00-4:50 pm

❒Tuesday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒3:00-3:50pm
❒4:00-4:50 pm

❒Wednesday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm
❒4:00-4:50 pm

❒Thursday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒3:00-3:50pm
❒4:00-4:50 pm

Secondary Option

❒Monday

❒ 9:00-9:50am ❒10:00-10:50 am
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❒Tuesday

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❒11:00-11:50 am ❒3:00-3:50pm
❒4:00-4:50 pm

❒Wednesday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm
❒4:00-4:50 pm

❒Thursday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒3:00-3:50pm
❒4:00-4:50 pm

____ I do not know my schedule for Fall '19 (for AAMU students only).

We will **attempt** to accommodate your preferred and secondary options. Please return these forms to your current student clinician as soon as possible, with a current email address as we will be sending updates re: clinical service via this venue. **We MUST have these forms back to include you on the list for the coming semester by August 16th**.

The Clinic is scheduled to open September 16th thru November 28th. Please make every effort to attend all therapy sessions to get the maximum benefit of therapy. Also be aware that attendance will be taken into consideration when scheduling for future semesters.

A graduate clinician will be contacting you to confirm therapy times for Fall '19 during the last week in August, through September 13th.

If you have any questions or concerns, please call or leave a voice mail message at 372-4044/5541. Feel free to write any more information that we may need in scheduling on the back of this form. Thank you for your continued support of our clinic. We look forward to working with you again.

Sincerely,

Mrs. Esther-Phillips-Ross

Mrs. Esther Phillips-Ross MA, CCC/SLP/L, Clinic Director
esther.phillips@aamu.edu
AAMU Communicative Sciences and Disorders Clinic

For Clinic Use Only: Dx _____ Tx _____ Case Hx _____ Referral _____
Comments:

Alabama A & M University

Speech-Language-Hearing Clinic
REQUEST FOR CLINICAL SERVICES
SPRING 2020

Client's Name: _____ DOB: _____ Age: _____

Spouse's/Parent's Name, if applicable: _____

Email address: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: home _____ work _____ other _____

Please circle/check the following information:

- Number of days per week you would prefer: 1 or 2
- Prefer: Individual Therapy or Group Therapy
- Preferred day(s) and time: Select BOTH preferred option and secondary option

Preferred Option

❒Monday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm
❒4:00-4:50 pm

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❒Wednesday

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❒4:00-4:50 pm

❒Thursday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒3:00-3:50pm
❒4:00-4:50 pm

Secondary Option

❒Monday

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❒Tuesday

❒ 9:00-9:50am ❒10:00-10:50 am
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❒Wednesday

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❒4:00-4:50 pm

❒Thursday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒3:00-3:50pm
❒4:00-4:50 pm

____ I do not know my schedule for Spring '20 (for AAMU students only).

We will **attempt** to accommodate your preferred and secondary options. Please return these forms to your current student clinician as soon as possible, with a current email address as we will be sending updates re: clinical service via this venue. **We MUST have these forms back to include you on the list for the coming semester by January 10th**.

The Clinic is tentatively scheduled to open February 17th thru April 24th. Make every effort to attend all therapy sessions to get the maximum benefit of therapy. Also be aware that attendance will be taken into consideration when scheduling for future semesters. A graduate clinician will be contacting you to confirm therapy times for Spring 2020 during the last week in January, early February. If you have any questions or concerns, please call or leave a voice mail message at 372-4044/5541. Feel free to write any more information that we may need in scheduling on the back of this form. Thank you for your continued support of our clinic. We look forward to working with you again.

Sincerely,

Mrs. Esther-Phillips-Ross

Mrs. Esther Phillips-Ross MA, CCC/SLP/L, Clinic Director
esther.phillips@aamu.edu
AAMU Communicative Sciences and Disorders Clinic

For Clinic Use Only: Dx _____ Tx _____ Case Hx _____ Referral _____
Comments:

Alabama A & M University

Speech-Language-Hearing Clinic
REQUEST FOR CLINICAL SERVICES
*SUMMER 2020

Client's Name: _____ **DOB:** _____ **Age:** _____

Spouse's/Parent's Name, if applicable: _____

Email address:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: home _____ work _____ other _____

Please circle/check the following information:

- Number of days per week you would prefer: 1 or 2
- Prefer: Individual Therapy or Group Therapy
- Preferred day(s) and time: Select BOTH preferred option and secondary option

Preferred Option

❒Tuesday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm

❒Thursday

❒ 9:00-9:50am ❒10:00-10:50 am
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❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm

____ I do not know my schedule for Summer '20 (ONLY for clients who are AAMU students).

We will **attempt** to accommodate your preferred and secondary options. Please return these forms to your current student clinician as soon as possible, with a current email address as we will be sending updates re: clinical service via this venue. **We MUST have these forms back to include you on the list for the coming semester by May 1st**.

The Clinic is tentatively scheduled to open June 16th thru July 16th. Please make every effort to attend all therapy sessions to get the maximum benefit of therapy. Also be aware that attendance will be taken into consideration when scheduling for future semesters.

A graduate clinician will be contacting you to confirm therapy times for Summer '20 during the last week in May/first week in June. If you have any questions or concerns, please call or leave a voice mail message at 372-4044/5541. Please feel free to write additional information that we should consider when scheduling, on the back of this form. Thank you for your continued support of our clinic. We look forward to working with you again.

Sincerely,

Mrs. Esther-Phillips-Ross

Mrs. Esther Phillips-Ross MA, CCC/SLP/L
Clinic Director
esther.phillips@aamu.edu
AAMU Communicative Sciences and Disorders Clinic

For Clinic Use Only: Dx _____ Tx _____ Case Hx _____ Referral _____
Comments: