UNIVERSITY OF CENTRAL OKLAHOMA

College of Education and Professional Studies
Department of Special Services
Speech Language Pathology

We are pleased that you contacted our program for evaluation services. Enclosed you will find:

1. Map with directions to our clinic
2. Case History questionnaire
3. Permission for Speech-Language-Hearing Evaluation

Please keep this letter and map for future reference.

Return items 2 and 3; completed Case History questionnaire and Permission for the evaluation to:

Clinic Coordinator
Speech and Hearing Clinic
University of Central Oklahoma
100 N. University Drive, Box 80
Edmond, OK 73034

Only when these items have been received by us can we set up a file and contact you to make an appointment. Appointments will be scheduled in order of receipt and availability of student clinicians. Keep in mind that we follow a fourteen-week fall and spring semester and a seven-week summer semester schedule. If you send us the completed case history form after or during a particular semester, it may be several weeks before you are contacted to arrange the appointment. Be assured that we will reach you as soon as possible.

The night before your appointment, the student clinician assigned to your evaluation will contact you to confirm this appointment. The clinician may at that time also wish to clarify any information provided on the forms. If you have copies of current educational or medical information pertaining to your communication concerns, it would be helpful if you could either send them with the above forms or bring them with you to the evaluation.

The evaluation may include assessment of the understanding and use of the English language, the clarity of speech, voice and fluency and hearing acuity. The evaluation will be performed by a graduate student clinician under the supervision of a faculty member that is certified by ASHA, the American Speech-Language-Hearing Association. The evaluation may also be observed by other students in the program. Confidentiality of your records and the evaluation session are always held in strictest regard.

If the client to be evaluated is a child, and they have questions about the procedure, you might very honestly and simply explain that he/she will get to wear earphones and listen to some little sounds. We require that **parents remain at the clinic during the entire evaluation period**.

The typical length of evaluation process is **between 2 and 3 hours.** Immediately following the evaluation, the results of the tests and recommendations will be discussed with you in person. A formal written evaluation report will be mailed to you approximately **one month** following the evaluation. If you wish for us to send a copy to another source, you will need to sign a **Release of Information Form** from UCO which is available at our clinic.

Our STANDARD fee schedule is as follows:

Speech-Language-Hearing Evaluation	**$150.00**
Hearing Evaluation Only	**$ 50.00**
Therapy Fall and Spring Semester (approx. 14 weeks)	$350.00
Therapy Summer Semester (approx. 7 weeks)	$175.00

The full payment for the evaluation is expected immediately following the appointment. Written reports will not be available until full payment is received.

Persons who receive state financial assistance or who attend or who are employed by UCO are eligible for a reduced fee. Please indicate in the space provided on page 1 of the Case History form if you would like us to send you an application for reduced fee.

Thank you for providing this opportunity for us to serve your communication needs. We look forward to hearing from you.

Linda Sealey-Holtz, PhD, CCC-SLP
Program Director
405-974-5297

Elaine Martindale, MS, CCC-SLP
Clinic Coordinator
405-974-5403

UNIVERSITY OF CENTRAL OKLAHOMA
SPEECH & HEARING CLINIC
CHILD CASE HISTORY FORM

DATE_____ **DATE FORM RECEIVED_____**
to be filled in by office staff

Person completing this form_____ Relationship to child _____

I. IDENTIFICATION

Child's Name_____Sex_____Birthdate_____Age_____

Address_____City/Zip_____Phone_____

Mother's Name_____Address_____Age_____

Occupation _____Work phone_____ Other phone _____

Father's Name_____Address_____Age_____

Occupation _____Work phone_____ Other phone _____

Referred by_____ Address_____

Child's Physician_____ Address_____

Primary language spoken in the home _____ Other languages_____

Persons currently receiving state financial assistance or who are either attending or employed by UCO, may be eligible for reduced fee status.
Check here if you would like us to send you an application for reduced fees YES____ NO____

II. STATEMENT OF THE CONCERN

Describe as completely as possible the speech, language, and/or hearing problem: _____
_____
_____
_____

When was the problem first noticed?_____ How has the problem changed since you first noticed it?
_____

What has been done about it?_____ How has it helped?_____

What do you think caused the problem?_____
_____

Describe any speech, language, hearing, psychological, and special education services that have been performed. Include service provider, dates and duration of service _____
_____
_____

III. SPEECH, LANGUAGE AND HEARING HISTORY

Indicate the ages the child reached the following milestones:

Babble and coo_____ First words spoken _____ Two word sentences _____

Complete sentences _____ Is speech used: frequently?_____ occasionally?_____ never?_____

If gestures are used, give examples _____
_____

Which does the child prefer to use? Complete sentences_____ One or two words_____ Sounds_____ Gestures_____

Describe speech sounds made incorrectly _____
_____

If your child hesitates, "gets stuck", repeats, stammers, or stutters on sounds or words, please describe_____
_____
_____

How (good, fair, poor) is the child understood by: parents? _____ siblings? _____
playmates?_____ distant relatives? _____ teachers? _____ strangers?_____

How does the child's voice sound? Normal_____Too High_____Too Loud_____ Hoarse_____ Nasal_____

If the child ever acquired speech and then slowed down or stopped talking, please describe _____
_____

If the child's speech is imitated, but not used independently, please describe _____
_____

How well does the child understand what is said? (good, fair, poor) _____

Does the child hear adequately?_____ If hearing varies, please describe _____
_____

If child wears a hearing aid, which ear? _____ How long?_____ Does it help?_____

NOTE : If the child has a hearing aid, please bring it and the earmold along with you when you come in for your appointment.

IV. BIRTH HISTORY

Total number of pregnancies_____ Explain miscarriages or stillbirths _____
_____

Which pregnancy was this child_____ Length of pregnancy_____Length of labor _____

Infant's birth weight _____ Age of mother at child's birth_____ Age of father at child's birth _____

Describe illness, disease or accidents occur during pregnancy _____
_____
_____
_____

Check these as they apply to the child.

	Yes	No	Explain
Was there an Rh incompatibility?			
Were drugs used during labor or delivery?			
During first two weeks of life, did the infant have significant problems with:			
swallowing?			
sucking?			
feeding?			
breathing?			
Did infant require oxygen?			
Jaundiced or "blue" at birth?			
Cesarean or breech delivery?			
Forceps or other instruments used?			
When did infant regain birth weight?			

V. DEVELOPMENTAL HISTORY

Indicate the ages the child reached the following milestones:

Held head erect while lying on stomach_____Rolled over _____ Sat alone unsupported_____
Crawled_____Stood alone_____ Walked with support _____ Walked alone _____
Fed self with spoon_____ Ate table foods _____ Had first tooth_____ Slept through night _____
Bladder trained during day_____ at night_____ Bowel trained during day_____ at night _____
Stopped bottle or breast feeding_____ Dressed and undressed with help _____ alone_____
Which hand is preferred?_____Has handedness ever been changed?_____ What age?_____
Describe your child's current physical development? _____
_____

Check these as they apply to the child.

	Yes	No	Explain; give ages when child began and ended if possible
Extremely sensitive to touch; vibration, cuddling, rocking, textures, temperatures, etc.			
Very alert to gestures, facial expressions, or movements.			
Responded to noises (cars, horns, telephones)			
Generally indifferent to sound			
Responded when spoken to			
Increased sensitivity to sounds			
Shuffled feet while walking			
Walked on tip toes			
Mouth breather			
Increased sensitivity to food textures, smells, temperatures, etc.			
Difficulty chewing			
Drooled excessively			
Difficulty breathing			
Large tongue			
Difficulty moving mouth or lips			
Constant throat clearing			
Thumb sucking or pacifier			

VI. MEDICAL HISTORY

If your child is under the care of a physician, please explain. _____

Current medications and conditions_____

Indicate the ages and severity of the following illness, problems or operations.

	Age	Mild	Moderate	Severe		Age	Mild	Moderate	Severe
Adeniodectomy					Heart problems				
Allergies					High Fevers				
Asthma					Influenza				
Blood Disease					Mastoidectomy				
Chicken Pox					Measles				
Chronic Colds					Meningitis				
Convulsions,seizures					Mumps				
Cross-Eyed					Muscle Disorder				
Croup					Nerve Disorder				
Dental Problems					Pneumonia				
Diphtheria					Polio				
Ear Aches					Rheumatic Fever				
Encephalitis					Scarlet Fever				
Headaches					Tonsilitis				
Head injuries					Tonsillectomy				
Ear Infections					Whooping Cough				

Please list any allergies to food, medications, dyes, materials, etc._____
_____
_____

If the child has ever had a severe blow to the head, did the child lose consciousness?_____Did it cause a concussion?_____nausea?_____vomiting?_____drowsiness?_____

Describe any other serious illness, injuries, operations, or physical problems not mentioned above.
_____
_____
_____

If illnesses have been accompanied by an extremely high fever, please describe length, severity and treatment.
_____
_____
_____

If any of the above illness ever resulted in hospitalizations, please describe length of stay, treatment and result.
_____
_____
_____

Ages of hospital stays, location and attending physicians _____
_____

Describe any health conditions or syndromes _____
_____
_____
_____

VII. BEHAVIOR

Check these as they apply to the child:

	Yes	No	Explain; give ages when child began and ended if possible
Eating Problems			
Sleeping Problems			
Toilet Training Problems			
Difficulty concentrating			
Stays with an activity			
Needs a lot of discipline			
Underactive			
Overactive			
Excitable			
Laughs easily			
Cries a lot			
Sensitive			
Personality problems			
Gets along with children			
Gets along with adults			
Makes friends easily			
Happy			
Shy			
Irritable			
Prefers to play alone			

Describe discipline methods you have found to be effective with the child _____
_____
_____

Describe the child's favorite play activities _____
_____
_____

VIII. EDUCATIONAL HISTORY

Day care or nursery school attended_____ Ages_____

School now attending_____Address_____

Current grade in school_____Grades skipped_____Grades repeated_____Average grades _____

Easiest subjects_____ Most challenging subjects_____

Describe any special programs or related services the child receives in school _____
_____
_____

Describe child's attendance and attitude toward school and teachers _____
_____

What is your impression of your child's learning abilities? __ _____
_____
_____

IX. HOME AND FAMILY INFORMATION

Persons residing in the home

NAME	RELATIONSHIP	AGE	SEX	SPEECH/LANGUAGE/HEARING/LEARNING PROBLEMS

Family members not residing in the home

NAME	RELATIONSHIP	AGE	SEX	SPEECH/LANGUAGE/HEARING/LEARNING PROBLEMS

Please add any information you feel will help us in understanding the child and their problem:

_____

_____

_____

_____

_____

_____

_____

UNIVERSITY OF CENTRAL OKLAHOMA

College of Education and Professional Studies
Department of Special Services
Speech Language Pathology

PERMISSION FOR SPEECH-LANGUAGE-HEARING EVALUATION / TREATMENT

I, _____, give permission to the University of Central Oklahoma Speech & Hearing Clinic to evaluate and/or treat the speech, language and hearing of _____, BIRTHDATE_____.

This program provides professional training at the undergraduate and graduate levels. The evaluation and any subsequent treatment may be performed by students supervised by licensed faculty of the Speech-Language Pathology Program. I further understand that these services may be observed by students in training for degrees in Speech-language Pathology at the University of Central Oklahoma.

All records pertaining to evaluation and treatment will be held for **SEVEN** years following discontinuation of services in this facility.

_____
Client / Parent or Guardian

_____
Date Signed