

CLIENT APPLICATION

Please complete and mail or fax to:
**Santa Rosa Scottish Rite Children's
Language and Learning Center**

625 Acacia Lane
Santa Rosa, CA 95409
Phone: 707-539-3003
Fax: 707-539-5905

PLEASE PRINT OR TYPE

DEVELOPMENTAL QUESTIONNAIRE

Please Fill Out Completely

Date: _____

Child's Name: _____

Age: _____ DOB: ____ / ____ / ____ Sex: M / F

School: _____

Home Address: _____ City: _____ Zip _____

Email: _____

Parent or Caregivers Name(s): _____

Referred by: _____

Please describe your child's speech/language/learning difficulties: _____

What are you concerned about? PDD/Autism Asperger's Syndrome

Developmental Delay Hearing Vision Speech/Language

Child's Primary Language: _____

Home or Primary Phone #: _____

Cell Phone#: _____

Work Phone#: _____

FAMILY INFORMATION HISTORY

Parents

Mother's Name: _____ **Age:** _____

Occupation/Employer _____

Phones: _____ Birthplace: _____

Father's Name: _____ **Age:** _____

Occupation/Employer _____

Phones: _____ Birthplace: _____

Parents are: Married ___ Never Married ___ Separated ___ Divorced ___ Deceased ___

Primary Caregiver (if other than above named parent): _____

Relationship to the child: _____ Phones: _____

Birthplace _____ Age: _____

Does family have a history of speech and language difficulties? Y / N

If yes, Please explain: _____

Siblings

Name	Age	Sex
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Do siblings have a history of speech and language difficulties? Y / N

If yes, please explain: _____

HEALTH INFORMATION HISTORY

At present

Describe your child's general health: _____

Does your child:

1) Wear glasses? Y / N

2) Have allergies? Y / N (list) _____

3) Currently sees a physician for conditions other than regular check-ups?

Explain: _____

4) Take medications? Y / N

Medication	To Treat What	Frequency	Side-effect

5) Seems to be emotionally and mentally healthy? Y / N

If no, explain: _____

6) Sees an orthodontist? Y / N For what reason? _____

Birth

Is the child adopted? Y / N Length of pregnancy: _____

Was the delivery normal? Y / N If no, explain: _____

Was the mother's health good during the pregnancy? Y / N

4 If no, explain: _____

During pregnancy, did the mother:

Smoke? Y / N Drink Alcohol? Y / N Use Drugs Y / N

Child's weight/condition at birth: _____

Development

Does your child have a history of ear infections? Y / N

If yes: Frequency _____ Treatment _____

At what age did your child reach these developmental milestones?

Sat up alone _____ Dressed self _____ Crawled _____

Walked alone _____ Toilet trained _____

Motor coordination is: Excellent ___ Good ___ Poor ___

Behavior/Discipline

Does your child have playmates in the neighborhood? Y / N

Seem to be a leader? _____ or a follower? _____

Prefer to play with people? _____ or things? _____

What seems to motivate your child? _____

What pleases you most about your child's behavior? _____

What bothers you most about your child's behavior? _____

Method of discipline used? _____

How often does your child need to be disciplined? _____

Discipline has been: Strict ___ Lenient ___ Inconsistent ___ Adequate ___

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COMMUNICATION DEVELOPMENT

Age of first words: _____ Age of first sentence _____

When did your child's speech/language/learning first concern you? _____

How has the family attempted to improve the child's communication? _____

What do you think may have caused this problem? _____

Has your child been seen or evaluated by:

Speech-Language Pathologist Y / N

Name: _____ Agency: _____ Date: _____

Developmental Psychologist Y / N

Name: _____ Agency: _____ Date: _____

Developmental Pediatrician Y / N

Name: _____ Agency: _____ Date: _____

Occupational Therapist Y / N

Name: _____ Agency: _____ Date: _____

****PLEASE ATTACH ANY OTHER SPEECH AND LANGUAGE AND/OR MEDICAL REPORTS THAT MAY BE PERTINENT TO YOUR CHILD'S THERAPY AT THIS CENTER**

Completed by: _____ Relationship _____

Parent Signature (required): _____

Parent Signature (required): _____

6 Complete this form only if you are requesting an evaluation or therapy for learning disabilities (dyslexia)

Name: _____ DOB: _____

Does your child know and speak English? Y / N

Is English your child's first language? Y / N

Which of these are you most concerned about? Reading Spelling

Math Handwriting Writing Stories Distractibility

Concentration Focus Hyperactivity Social Skills

Sadness Worry Moodiness/Irritability Argues

Suicidal Tendencies Gets in Trouble Temper/Anger Control

Does your child receive special help at school or has he/she in the past? Y / N

Check all that apply:

Tutoring Resource Specialist Speech ESL

Inclusion Occupational Therapy Other

Have you ever been to a school meeting for this child to receive help? Y / N

IN ORDER FOR YOUR APPLICATION TO BE COMPLETE, YOU MUST PROVIDE ALL PREVIOUS TEST SCORES, SUCH AS ACHIEVEMENT TESTS.

Is there a plan for this child to be tested by the school or another private agency?
Y / N

Has your child seen a doctor about attention or behavior problems and/or taken medicine to help with attention or behavior? Y / N

If yes, what medicine(s) and when did your child first start taking the medication?

7 Name: _____ DOB: _____

Does your child have any medical diagnoses?

___ ADHD/ADD ___ Allergies ___ Autism ___ Bipolar Disorder

___ Cerebral Palsy ___ Cleft Palate/Cleft Lip ___ Conduct Disorder

___ Depression ___ Developmental Delay ___ Fetal Alcohol Syndrome

___ Fragile X ___ Obsessive Compulsive Disorder ___ PDD

___ Seizure Disorder ___ Other _____

8 PERMISSION TO CONFER WITH OUTSIDE PROFESSIONALS

Client's Name: _____ DOB: _____

I hereby give permission to the Santa Rosa Scottish Rite Children's Language and Learning Center to contact other professionals working with my child. The purpose of this contact will be to share information in order to make treatment as integrated as possible. This permission will remain in effect until my child is no longer receiving services from the Center.

Please identify other professionals/agencies providing services to your child:

_____ Speech-Language Pathology Services (Specify) _____

_____ Hospital _____

_____ Private Speech-Language Pathologist(s) (Name) _____

_____ Psychologist _____

_____ Regional Center (Name of Contact) _____

_____ School: Speech-Language Pathologist _____

 Teacher _____

_____ Other _____

Signature: _____ Date: _____

9 AUTHORIZATION FOR RELEASE OF INFORMATION (OUTGOING)

Client's Name: _____ DOB: _____

I, the undersigned, hereby authorize the Santa Rosa Scottish Rite Childhood Language and Learning Center to provide information from the records of the above-named client to the following person or agency:

Name: _____

Agency: _____

Address: _____ City: _____ Zip: _____

Function of person or agency to which disclosure is to be made: _____

This information may be disclosed to the following:

_____ Physician(s)

_____ School District

_____ Other: _____

The undersigned may withdraw this authorization upon written notice received by the Santa Rosa Scottish Rite Children's Language and Learning Center at any time prior to the release of the information. This permission will remain in effect until the client is no longer receiving services from the Center.

A copy of this authorization is available for the personal records of the undersigned.

Signature: _____ Date: _____

Relation to client: _____ Mother _____ Father _____ Legal Guardian

_____ Grandparent _____ Other

10 CONSENT FOR RELEASE OF INFORMATION (INCOMING)

The undersigned hereby authorizes _____
Person / Agency

_____, and any institution, school,
Address

physician, or professional to release information relating to the treatment and/or

education of _____,
Client's Name Date of Birth

_____, to the Santa Rosa Scottish Rite
Client's Address

Children's Language and Learning Center, 625 Acacia Ln, Santa Rosa, CA 95409.

The undersigned hereby waives any and all rights on behalf of the parties whose information is being released and the right to any privilege or privacy between the Santa Rosa Scottish Rite Children's Language and Learning Center and the institution, agency school, physician, or professional. This authorization extends to the furnishing of copies of all or any part of the records pertaining to the above-names client.

You are hereby released from all legal liability that may arise by providing any information requested from the Santa Rosa Scottish Rite Children's Language and Learning Center.

This permission will remain in effect until the client is no longer receiving services from the Santa Rosa Scottish Rite Children's Language and Learning Center.

SIGNATURE: _____ DATE: _____

Relation to client: ___ Mother ___ Father ___ Legal Guardian

___ Grandparent ___ Other

11 SPEECH-LANGUAGE PATHOLOGY SERVICE SURVEY

Date: _____

Child's Name: _____ DOB: _____

Parents' Names: _____ Phone: _____

Address: _____

1. Is your child receiving speech therapy in school? Y / N

2. If you answered YES, please include the following information:

a. Name of speech-language pathologist _____

b. School _____

c. Number of times per week _____

d. Length of therapy sessions _____

e. Individual or group therapy _____

f. If group, how many children in the group _____

3. Does the child receive any speech therapy other than in the schools? N / Y

4. If you answered YES, please provide the following information:

a. Agency providing the therapy _____

b. Name of therapist _____

c. Number of times per week _____

d. Length of therapy sessions _____

e. Is treatment individual or group _____

f. If group, how many children in the group _____

**It is important that you list all speech therapy services that your child present receives to avoid any complications at a later date.

AUTHORIZATION FORM

_____ I hereby give permission for a speech and language evaluation to be performed at the Santa Rosa Scottish Rite Children's Language and Learning Center. I understand that the purpose of this evaluation is to determine the nature and extent of my child's speech/language/learning difficulties. This evaluation will be performed by a certified, licensed speech-language pathologist, or a Clinical Fellow who is under the supervision of a certified, licensed speech-language pathologist. All reports regarding this evaluation will be confidential and remain the the Center files unless otherwise requested by me.

_____ I hereby give permission for speech-language therapy be provided to my child at the Santa Rosa Scottish Rite Children's Language and Learning Center. This therapy shall be provided by a certified, licensed speech-language pathologist, or a Clinical Fellow who is under the supervision of a certified, licensed speech-language pathologist or a registered speech-language pathology assistant under the supervision of a certified, licensed speech-language pathologist.

Signature: _____

Relationship to the client: _____

Client's name: _____

Date: _____