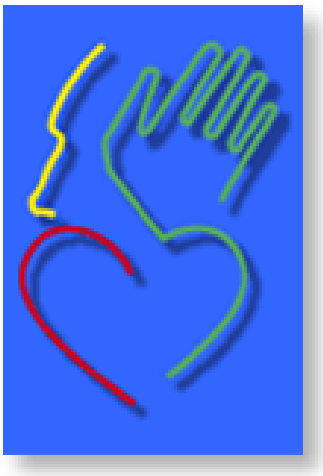
CALIFORNIA STATE UNIVERSITY LOS ANGELES

The Robert L. Douglass Speech and Language Clinic



Department of
Communication Disorders

Our goal is to serve individuals with communication disorders in the most effective and humane manner possible.

At the Robert L. Douglass Speech-Language Clinic we provide a full range of diagnostic and therapeutic services in a university environment. Our clients include adults, preschoolers, and school-age children with a variety of communication disorders. We do not discriminate on the basis of race, color, national origin, disability, sex, gender, or sexual orientation.

The Clinic is part of a graduate degree program that is accredited by the Council on Academic Accreditation (CAA). As such, we maintain high standards in the provision of comprehensive assessment and intervention services.

Clinical Philosophy

The Department of Communication Disorders here at Cal State LA embraces a philosophy of clinical service delivery that is consistent with the ethical standards, scope of practice, and current standards of practice of the American Speech-Language-Hearing Association (ASHA). Our goal is to serve individuals with communication disorders in the most effective and humane manner possible, and to ensure that our students commit themselves to this fundamental clinical value. In training our students we emphasize the importance of holding paramount the well-being of clients as well as their families and caregivers. The importance of involving families and caregivers in all aspects of the therapeutic process is also stressed.

Services Offered

We provide services for both children and adults with speech sound, language, cognitive, voice, fluency, and hearing disorders.

The Staff

All services are provided by graduate clinicians who are supervised by faculty and clinic staff members holding California licensure and ASHA's certificate of clinical competence.

Fees

The Clinic offers fees that are based on a sliding scale depending on income and number of dependents. Individual insurance policies may cover part of the cost of assessment and intervention, and we are happy to assist clients in processing the necessary paperwork. Free, convenient parking is provided.

For More Information – To receive additional information or to inquire about the services offered, please call (323) 343-4690. The Clinic is open from 9am to 6pm Monday Through Thursday, and 9am to 12 Noon on Friday. The Clinic is located in the basement level of King Hall on the inner campus of Cal State LA adjacent to Parking Lot 8 on Circle Drive.

CALIFORNIA STATE UNIVERSITY, LOS ANGELES

Department of Communication Disorders
5151 State University Drive
Los Angeles, CA 90032
(323) 343-4754 or 343-4690

Confidential

DATE: _____

THE ROBERT L. DOUGLASS SPEECH-LANGUAGE CLINIC

CASE HISTORY FORM – CHILD

Client (child): _____ Sex: M ____ F ____

Date of Birth: _____ Age: _____

Place of Birth:_____

Home Address: _____ _____ _____
Number/Street City Zip

Home Telephone Number: ( ) _____

Name of person completing this form:_____

Relationship to client:_____

Name of person who referred you to this clinic: _____

Professional position:_____

LEGAL GUARDIAN(S)

1. Name: _____ Date of Birth: _____

   Relationship: _____ Education completed: _____

   Occupation: _____ Employer: _____

   Cell phone number: (_____)_____ Work phone number: (_____)_____

   If you check your email daily and it is OK for us to contact you this way, fill in your address below:

   _____

2. Name: _____ Date of Birth: _____

   Relationship: _____ Education completed: _____

   Occupation: _____ Employer: _____

   Cell phone number: (_____)_____ Work phone number: (_____)_____

   If you check your email daily and it is OK for us to contact you this way, fill in your address below:

   _____

Relationship of legal guardians to each other: _____

If the legal guardians are not the child's parents, explain why:_____

FAMILY HISTORY

Names of Brothers & Sisters	Age	Sex	Grade In School	Special Problems?

Others living in the home in addition to legal guardian(s) and siblings	Relationship to Child

Language(s) Spoken in the Home:

What language is used most often by:

first legal guardian to the child: ____English ____ Other (_____)

second legal guardian to the child: ____English ____ Other (_____)

brothers and sisters to the child: ____English ____ Other (_____)

legal guardians to each other: ____English ____ Other (_____)

brothers and sisters to each other: ____English ____ Other (_____)

Are there languages besides English spoken to the child in addition to the language(s) listed above?

___ Yes ___ No If yes, explain: _____

BIRTH AND DEVELOPMENTAL HISTORY

Pregnancy

Length (in weeks): _____ Labor (in hours): _____ Birth Weight: _____

Mother's health during pregnancy: ___ Excellent ___ Good ___ Fair ___ Poor

Was the mother given drugs during pregnancy? ___ Yes ___ No

Was the mother given drugs during the delivery? ___ Yes ___ No

Were forceps used during the delivery? ___ Yes ___ No

Describe any complications during or immediately after delivery: _____

_____

Past or Present Problems

Feeding problems	___	Bedwetting	___
Sleeping problems	___	Seizures	___
High fevers	___	Overactivity	___
Unusual fears	___	Undue sensitivity	___
Behavior problems	___	Accident prone	___
Clumsy	___		

For each of the items checked above, please give an explanation:

_____

_____

_____

_____

_____

(Please use other side of this page if you need more room)

Development

Give approximate ages for each of the following milestones in months.

Language: Babbling _____ First Words _____ Two Word Phrases _____ Sentences _____

Gross Motor: Sat alone _____ Crawled _____ Walked Alone _____ Stood Alone _____

Fine Motor: Fed Self w/ Spoon _____ Dressed Self _____ Tied Shoes _____ Printed Name _____

Toilet Trained: Bladder _____ Bowel _____ Night _____

Miscellaneous

What do you consider your child's main assets?

_____

_____

_____

_____

What are your most frequent discipline problems with your child?

_____

_____

_____

Who does the disciplining? _____

How do you discipline? _____

_____

MEDICAL HISTORY

Name and address of regular family physician or pediatrician:

_____ _____
Name Address

List illnesses, injuries, childhood diseases and operations. Give dates and length of disability. Include any physical handicaps.

Illness, Injury or Operation	Date	Hospital/Address

Is child under any medication at present time? Yes ___ No ___

If yes, what medication? _____

Are there any known defects of tongue, palate, nose, ears, etc.? Yes ___ No ___

If yes, please describe: _____

Does child have any hearing problems? Yes ___ No ___

If yes, please explain: _____

Date of last evaluation: _____ By whom: _____

Please list any medical/psychological diagnosis that your child has received: _____
_____
_____

SCHOOL HISTORY

Name of school presently attending: _____

Address: _____ _____ _____
Number/Street City Zip

Grade: _____

List any special classes attended: _____
_____
_____

SPEECH/LANGUAGE HISTORY

Describe the speech/language concern: _____
_____
_____
_____
_____

Rate clarity of speech: Fair ___ Good ___ Poor ___

At what age was the speech/language problem first noticed? _____

Did it follow illness, accident or unusual occurrence? _____

Was there any period when speech/language development seemed to have stopped? Yes___ No ___

If yes, what do you believe was the cause, and how long did it last? _____
_____

Has your child's speech/language changed in the last six months? Yes ___ No ___

If yes, describe how it improved or regressed: _____
_____

How did (does) child make wants known? _____
_____
_____

What is your child's attitude toward his speech/language? _____
_____
_____

Do other members of the family have speech/language problems? Yes ___ No ___

If yes, please describe: _____
_____

What situations do you feel have affected your child's speech/language problem?_____
_____
_____

List psychological, speech and hearing testing and/or therapy:

Testing or Therapy	Institution	Date
	Name: Address: City, State, Zip:	
	Name: Address: City, State, Zip	
	Name: Address: City, State, Zip	

Did such testing result in a diagnosis? Yes ___ No ___

If yes, describe: _____

What are your major concerns regarding your child? _____
_____
_____
_____
_____
_____
_____
_____
_____

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Los Angeles, CA 90032-8170
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FINANCIAL WORKSHEET

Client's Name: _____ Date: _____

Person(s) financially responsible:_____

Address: _____
Number/Street City State Zip Code

Phone number: (____)_____ Relationship to client: _____

Clinic fees are $120 for a diagnostic evaluation and $840 for treatment (14 week semester).

- ☐ I request a reduction in fees (complete reverse side of form, sign and return)
- ☐ I will pay full fees for services (sign form and return)

_____ _____
Signature of Person Financially Responsible Date

SPEECH-LANGUAGE CLINIC USE ONLY:

Fee set by: _____

Diagnostic Fee: $_____ (Per Session)

Therapy Fee: $_____ (Per Semester)

PLEASE COMPLETE THE FOLLOWING FINANCIAL INFORMATION
(if requesting a reduction in fees)

Employment Information of Person Financially Responsible:

Employed by: _____

Address: _____
Number/Street City State Zip Code

Phone number: (____)_____ **Monthly Salary**: $_____

Employment Information of Another Person Who Contributes to Household Income:

Employed by: _____

Address: _____
Number/Street City State Zip Code

Phone number: (____)_____ **Monthly Salary**: $_____

Source of Other Household Income: _____

Amount (Monthly): $_____

TOTAL YEARLY INCOME: $_____

Number of persons dependent on this income: _____

Other information relevant to fee reduction (loans, credit card debt, balance due to doctors and other clinics/hospitals, etc.):

_____

_____

_____

_____

_____

_____

I hereby affirm that each of the answers in the foregoing application are true and correct and authorize you to obtain information from any source(s) to which you may apply relative to this application.

_____ _____
Signature of Person Financially Responsible Date

CALIFORNIA STATE UNIVERSITY, LOS ANGELES
ROBERT L. DOUGLASS SPEECH AND LANGUAGE CLINIC

PRIVACY NOTICE AND CONSENT FORM

The Robert L. Douglass Speech and Language Clinic is a training service agency. Our services to clients are provided by students who are supervised by faculty members. In order to provide this supervision and promote student learning through observation, our clinic rooms have special equipment – one-way observation windows, TV monitors, and audio and/or video recording devices. Occasionally a video or audiotape will be saved beyond the time of direct services because it is considered a good example for training purposes. These tapes are subject to all the confidential restrictions mentioned below.

Keeping client information confidential and secure, and using it only as our clients would want us to, is a top priority for all of us at the Robert L. Douglass Speech and Language Clinic. Here, then, is our promise to our clients and their families:

1. We will safeguard, according to strict standards of confidentiality and security, any information that clients share with us. What is discussed as part of the therapy process is confidential unless and until you give consent to its release.
2. We will permit only authorized employees, students, and instructional staff who are trained in the proper handling of client information to have access to that information.
3. We will not reveal client information to any external organization unless we have previously informed the client in disclosures or agreements, have been authorized by the client to share the information, or are required by law to reveal that information.
4. We will always maintain control over the confidentiality of our client information.

In short, any personal information that we collect about you or your family will be protected by physical, electronic, and procedural safeguards that meet or exceed applicable law. Finally, information obtained from clients may be used for research purposes. If this occurs, information will be handled professionally, treated confidentially, and any identifying information about the client is removed.

I have read the above policy statements and agree to these conditions.

_____	_____
Signature of Client	Signature of Parent or Legal Guardian
_____	_____
Print Client's Name	Date