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.
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

<table>
<thead>
<tr>
<th>Names of Brothers &amp; Sisters</th>
<th>Age</th>
<th>Sex</th>
<th>Grade In School</th>
<th>Special Problems?</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Others living in the home in addition to legal guardian(s) and siblings</th>
<th>Relationship to Child</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Language(s) Spoken in the Home:</th>
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</thead>
<tbody>
<tr>
<td>What language is used most often by:</td>
</tr>
<tr>
<td>first legal guardian to the child:   _<strong>English  ___ Other (</strong>____________________)</td>
</tr>
<tr>
<td>second legal guardian to the child:   _<strong>English  ___ Other (</strong>____________________)</td>
</tr>
<tr>
<td>brothers and sisters to the child:    _<strong>English  ___ Other (</strong>____________________)</td>
</tr>
<tr>
<td>legal guardians to each other:        _<strong>English  ___ Other (</strong>____________________)</td>
</tr>
<tr>
<td>brothers and sisters to each other:   _<strong>English  ___ Other (</strong>____________________)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Length (in weeks):</th>
<th>Labor (in hours):</th>
<th>Birth Weight:</th>
</tr>
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<tbody>
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</table>

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.

<table>
<thead>
<tr>
<th>Illness, Injury or Operation</th>
<th>Date</th>
<th>Hospital/Address</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Testing or Therapy</th>
<th>Institution</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>City, State, Zip:</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>Address:</td>
<td></td>
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<td>Address:</td>
<td>City, State, Zip</td>
<td></td>
</tr>
</tbody>
</table>

Did such testing result in a diagnosis?    Yes ___ No ___
   If yes, describe: __________________________________________________________________________

What are your major concerns regarding your child? _____________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
FINANCIAL WORKSHEET

Client’s Name: ____________________________ Date: ____________

Person(s) financially responsible: ____________________________________________________

Address: ____________________________________________

<table>
<thead>
<tr>
<th>Number/Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

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: ______________________________________________________________

<table>
<thead>
<tr>
<th>Number/Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Phone number: (____)_________________  Monthly Salary: $________________

Employment Information of Another Person Who Contributes to Household Income:

Employed by: __________________________________________________________

Address: ______________________________________________________________

<table>
<thead>
<tr>
<th>Number/Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

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
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