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-Embden  
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-Embden

Esther Phillips-Embden MA,CCC/SLP/L  
Assistant Professor/Director of Clinical Services  
Communicative Sciences and Disorders Clinic  
Alabama A&M University
Alabama A & M University (the University) recognizes that the best way to prevent illness is to avoid being exposed to COVID-19. The University will take proactive steps to decrease the spread of COVID-19 and reduce its impact upon its faculty, staff, and visitors. To aid in this endeavor, the University encourages sick individuals to stay at home, identifying where and how they may be exposed to COVID-19 and taking steps to reduce those potential exposures.

Masks and social distancing will be required in the clinic until otherwise noted.

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

Mrs. Shawn Pair, AAMU CSD and Clinic Secretary
372-5541

Dr. Diana Blakney-Billings, Associate Professor, CSD Program Coordinator,
Audiologist, Audiology Clinic
Au.D,CCC-A
372-5541

Ms. Esther Phillips-Embden, Assistant Professor, Director of Clinical Services
M.A., CCC-SLP/L
372-4044

Dr. Hope Reed, Associate Professor, Orofacial Myologist
CCC-SLP-D
372-4036

Dr. Caroline Gammill, Assistant Professor, TBI Clinic
CCC-SLP, CBIS
372-4124

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](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 AAMU CSD Clinic is currently closed for face-to-face services during the COVID-19 pandemic. Speech and language services will be rendered via virtually/telepractice. When the AAMU CSD Clinic is open to the public, its waiting room will be for families of the clients enrolled in clinical services. Masks and social distancing protocols will be in place. 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.

COVID-19 Procedures

When the AAMU CSD Clinic opens to the public, the use of face masks will be required along with social distancing. When the waiting room has met is capacity, families will be asked to wait in their cars until ‘safe space’ becomes available in the clinic. Clients are asked to respect the COVID-19 protocols set in place.

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) -- Ms. Phillips-Embden, 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, Ms. Phillips-Embden.
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:

<table>
<thead>
<tr>
<th>DISEASE/VIRUS</th>
<th>MINIMUM PERIOD OF ISOLATION OF THE CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19</td>
<td>If individuals are not exhibiting signs or symptoms of COVID19, they may be permitted to enter the clinic for speech, language and hearing services. Temperatures will be taken upon entry to the clinic. The use of masks is required. If individuals have been exposed to</td>
</tr>
</tbody>
</table>
someone with COVID or themselves have signs and symptoms of COVID, such individuals will be asked not to visit the clinic until they have been quarantined for the recommended period.

**Who needs to quarantine?** People who have been in **close contact** with someone who has COVID-19—excluding people who have had COVID-19 within the past 3 months or **who are fully vaccinated**.

- People who have tested positive for COVID-19 within the past three (3) months and recovered do not have to quarantine or get tested again as long as they do not develop new symptoms.
- People who develop symptoms again within three (3) months of their first bout of COVID-19 may need to be tested again if there is no other cause identified for their symptoms.
- People who have been in close contact with someone who has COVID-19 are not required to quarantine if they have been **fully vaccinated** against the disease and show no symptoms.

**What counts as close contact?**

- You were within three (3) feet of someone who has COVID-19 for a total of 15 minutes or more
- You provided care at home to someone who is sick with COVID-19
- You had direct physical contact with the person (hugged or kissed them)
- You shared eating or drinking utensils

**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


We wish you the best possible success here in the clinic. Together, we can make a difference!
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
# CASE HISTORY FORM – CHILD

## IDENTIFYING INFORMATION/SOCIAL/EDUCATIONAL HISTORY

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>_______________________________________________</th>
<th>Sex ____</th>
</tr>
</thead>
</table>
| 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:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Occupation</th>
<th>Education</th>
<th>Work #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>_______________________</td>
<td>____</td>
<td>__________</td>
<td>____________</td>
</tr>
<tr>
<td>Mother</td>
<td>_______________________</td>
<td>____</td>
<td>_________</td>
<td>____________</td>
</tr>
<tr>
<td>Guardian</td>
<td>_______________________</td>
<td>____</td>
<td>_________</td>
<td>______________</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Grade/School</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

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: ________________________________________________________________
COMMUNICATION/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?

<table>
<thead>
<tr>
<th>Siblings?</th>
<th>Friends?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relatvies?</td>
<td>Strangers?</td>
</tr>
</tbody>
</table>

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:

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

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:

<table>
<thead>
<tr>
<th>Hospital/City/State</th>
<th>Dates</th>
<th>Reason</th>
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</tbody>
</table>

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:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sinus infections</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Anemia</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Asthma</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Broken nose</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Bronchitis</td>
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<td>☐</td>
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<tr>
<td>Chronic colds</td>
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<tr>
<td>Chronic laryngitis</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Chronic ear infections</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Cleft palate</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Diabetes</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Heart trouble</td>
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<tr>
<td>Numbness</td>
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<td>☐</td>
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<tr>
<td>Paralysis//paresis</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Incoordination of face or tongue</td>
<td>☐</td>
<td>☐</td>
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<td>Influenza</td>
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<td>Mouth-breathing</td>
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<td>Mumps</td>
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<td>Pneumonia</td>
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<td>Tuberculosis</td>
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<td>Poliomyelitis</td>
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<td>Seizures</td>
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<tr>
<td>Condition</td>
<td>Yes</td>
<td>No</td>
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<td>Hypertension</td>
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<td>CVA/Stroke</td>
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<td>Thyroid Issues</td>
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<td>Facial Nerve Palsy</td>
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<td>Acid Reflux</td>
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<td>Diptheria</td>
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<td>Ear Infection</td>
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<td>Hearing aid</td>
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<td>Hormone therapy</td>
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<td>Hyperthyroidism</td>
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<tr>
<td>Emotional difficulty</td>
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</table>

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 _______________________


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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
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</table>

EDUCATION

<table>
<thead>
<tr>
<th>School</th>
<th>Location</th>
<th>Highest Grad or Degree Completed</th>
<th>Date</th>
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MEDICAL HISTORY: DESCRIBE YOUR PRESENT HEALTH

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</table>

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:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
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<td>Tuberculosis</td>
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<tr>
<td>Diabetes</td>
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<td>Seizures</td>
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<tr>
<td>Hypertension</td>
<td></td>
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<td>Head Injury</td>
<td></td>
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<tr>
<td>CVA/Stroke</td>
<td></td>
<td></td>
<td>Neurological Conditions</td>
<td></td>
<td></td>
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<tr>
<td>Chronic Laryngitis</td>
<td></td>
<td></td>
<td>Cancer</td>
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<tr>
<td>Pneumonia</td>
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<td></td>
<td>Cerebral Palsy</td>
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<tr>
<td>Thyroid Issues</td>
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<td>Intellectual deficits</td>
<td></td>
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<tr>
<td>Facial Nerve Palsy</td>
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<td></td>
<td>Emotional/Psychological Issues</td>
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<tr>
<td>Multiple Sclerosis</td>
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<td>Huntington's/Parkinson's</td>
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<tr>
<td>Voice Issues</td>
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<td>Vocal Polyps or Nodules</td>
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<td>Acid Reflux</td>
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<td>Psychological counseling</td>
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<tr>
<td>Diphtheria</td>
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<td>Rheumatic fever</td>
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<td>Ear Infection</td>
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<td>Scarlet fever</td>
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<td>Glandular imbalance</td>
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<td>Tremor/twitching</td>
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<tr>
<td>Hearing problem</td>
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<td>Ulcers</td>
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<tr>
<td>Hearing aid</td>
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<td>Visual problems</td>
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<tr>
<td>Hormone therapy</td>
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<td>Glasses</td>
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<tr>
<td>Hyperthyroidism</td>
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<td>Other</td>
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<tr>
<td>Emotional difficulty</td>
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<tr>
<td>Smoking</td>
<td></td>
<td></td>
<td>Amount Per Day?</td>
<td></td>
<td></td>
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<tr>
<td>Drinking</td>
<td></td>
<td></td>
<td>Amount Per Day?</td>
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</tbody>
</table>

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

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

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- Embden MA, CCC/SLP/L
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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relation</th>
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<tbody>
<tr>
<td>__________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Relation</th>
</tr>
</thead>
</table>

Self/Guardian Signature __________________ Date __________________

Updated 2/22/2018
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, 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
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-Embden, Director of Clinical Services  
P O Box 357  
Normal, AL  35762  
esther.phillips@aamu.edu

Thank you for your 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)

__________________________ Date: _________________________  
(Signature of guardian required if client is under 18 years)

Updated 7/14/2014
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
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

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____ I do not know my schedule for Summer ’21 (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 14th 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 ’21 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,

Ms. Esther-Phillips-Embden
Ms. Esther Phillips-Embden 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:
REQUEST FOR CLINICAL SERVICES
FALL 2021

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

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_____ I do not know my schedule for Fall ’21 (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 13th thru November 19th. 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 ’21 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,

Ms. Esther Phillips-Emden
Ms. Esther Phillips-Emden MA, CCC/SLP/L, Clinic Director
ester.phillips@aamu.edu
AAMU Communicative Sciences and Disorders Clinic

For Clinic Use Only: Dx ___________ Tx ___________ Case Hx ___________ Referral ___________

Comments:
Albama A & M University

Speech-Language-Hearing Clinic

REQUEST FOR CLINICAL SERVICES

SPRING 2022

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

• 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 □ 3:00-3:50 pm
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 Tuesday

  □ 9:00-9:50am □ 10:00-10:50 am
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 Wednesday

  □ 9:00-9:50am □ 10:00-10:50 am
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 Thursday

  □ 9:00-9:50am □ 10:00-10:50 am
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  □ 4:00-4:50 pm

Secondary Option

 Monday

  □ 9:00-9:50am □ 10:00-10:50 am
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 Thursday

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____ I do not know my schedule for Spring ‘22 (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 14th thru April 22nd. 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 2022 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,

Ms. Esther Phillips-Emden
Ms. Esther Phillips-Emden 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:
REQUEST FOR CLINICAL SERVICES
*SUMMER 2022

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

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I do not know my schedule for Summer ‘22 (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 9TH.

The Clinic is tentatively scheduled to open June 13TH thru July 15TH. 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 ‘22 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.

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Clinic Director
esther.phillips@aamu.edu
AAMU Communicative Sciences and Disorders Clinic

For Clinic Use Only: Dx ___________ Tx ___________ Case Hx ___________ Referral ___________

Comments:
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:

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* Prefer: Individual Therapy or Group Therapy
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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 15th**.

The Clinic is scheduled to open September 12th thru November 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 Fall ‘22 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,

Ms. Esther-Phillips-Embden

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esther.phillips@aamu.edu

AAMU Communicative Sciences and Disorders Clinic

For Clinic Use Only: Dx _________ Tx _________ Case Hx _____________ Referral _____________

Comments: