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-Ross  
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-Ross

Esther Phillips-Ross MA,CCC/SLP/L  
Assistant Professor/Director of Clinical Services  
Communicative Sciences and Disorders Clinic  
Alabama A&M University
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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<td>7</td>
</tr>
</tbody>
</table>
CSD CLINICAL FACULTY/STAFF

Ms. Nelka Ortega Cotto (Nicky), AAMU CSD and Clinic Secretary
372-5541

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

Mrs. Jennifer Horne, Assistant Professor, Clinical Supervisor
M.S. CCC-SLP/L
372-4035

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

Dr. Carol Deakin, Associate Professor, Clinical Supervisor, TBI Specialist
Ph.D, CCC-SLP/L
372-4043

Dr. Diana Blakney-Billings, Associate Professor, Audiolist, Audiology Clinic
Au.D,CCC-A
372-5541

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 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 waiting room is for families of the clients enrolled in clinical services. 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.

**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) -- Mrs. Phillips-Ross, 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, Mrs. Phillips-Ross.

**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</th>
<th>MINIMUM PERIOD OF ISOLATION OF THE CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken Pox (varicella)</td>
<td>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.</td>
</tr>
<tr>
<td>Conjunctivitis (Pinkeye)</td>
<td>Individual must remain home until 24 hours after treatment (antibiotic eye drops) is initiated.</td>
</tr>
<tr>
<td>German Measles</td>
<td>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.</td>
</tr>
<tr>
<td>Impetigo</td>
<td>Individual must remain at home until 24 hours after treatment is initiated.</td>
</tr>
<tr>
<td>Influenza</td>
<td>Individual must remain home until no fever is detected for 24 hours.</td>
</tr>
<tr>
<td>Lice (Pediculosis)</td>
<td>Individual must remain at home until the morning after treatment.</td>
</tr>
</tbody>
</table>
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

Child’s Name ____________________________________________________ Sex __________
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: Name Age Occupation Education Work #
Father ______________________ __    __________________________ __________ __________
Mother ______________________ __    __________________________ __________ __________
Guardian____________________ __    __________________________ __________ __________

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:
Name __________________________ Sex ______ Age ______ Grade/School _________________________________
____________________________________     _____     ______
____________________________________     _____     ______
____________________________________     _____     ______

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  
_____ required oxygen       _____ infection diagnosed  
_____ breathing problems    _____ 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  _______
Case History Form – Child – page 4

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?
   Siblings?  _____________________________  Friends?  _____________________________
   Relatives?  ____________________________  Strangers?  ___________________________

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>
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<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>
</tr>
<tr>
<td>Needed a lot of discipline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underactive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excitable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laughs easily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cried a lot</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Difficult to manage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overactive</td>
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<td></td>
<td></td>
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<tr>
<td>Sensitive</td>
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<tr>
<td>Personality problem</td>
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<tr>
<td>Gets along with children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gets along with adults</td>
<td></td>
<td></td>
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<tr>
<td>Emotional</td>
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<tr>
<td>Stays with an activity</td>
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<td></td>
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<tr>
<td>Makes friends easily</td>
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<td></td>
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<tr>
<td>Happy</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Irritable</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Prefers to play alone</td>
<td></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>
</tr>
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<tbody>
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</tbody>
</table>

List all prescription and nonprescription medication currently used.

__________________________

Has your child had a neurological examination? □ yes □ no
If so, by whom, when, and where?

__________________________

Is there a medical history of:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinus infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
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<tr>
<td>Broken nose</td>
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<tr>
<td>Bronchitis</td>
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<tr>
<td>Chronic colds</td>
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<tr>
<td>Chronic laryngitis</td>
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<tr>
<td>Chronic ear infections</td>
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<tr>
<td>Cleft palate</td>
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<tr>
<td>Diabetes</td>
<td></td>
<td></td>
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</tr>
</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.)

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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

EDUCATION

<table>
<thead>
<tr>
<th>School</th>
<th>Location</th>
<th>Highest Grad or Degree Completed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</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
Case History Form – Adult – page 3

Is there a medical history of:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinus infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Diabetes</td>
<td></td>
<td></td>
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<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVA/Stroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Laryngitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facial Nerve Palsy</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Multiple Sclerosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Voice Issues</td>
<td></td>
<td></td>
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<tr>
<td>Acid Reflux</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Diphtheria</td>
<td></td>
<td></td>
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<tr>
<td>Ear Infection</td>
<td></td>
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<tr>
<td>Glandular imbalance</td>
<td></td>
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<tr>
<td>Hearing problem</td>
<td></td>
<td></td>
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<tr>
<td>Hearing aid</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hormone therapy</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Hyperthyroid</td>
<td></td>
<td></td>
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<tr>
<td>Emotional difficulty</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drinking</td>
<td></td>
<td></td>
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</tr>
</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>
</tr>
<tr>
<td>Difficulty being understood by others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty understanding what others are saying to you</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orientation/memory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem solving</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focusing/attention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading/writing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finding words</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining topic of conversation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluent speech (stuttering)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Following directions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral motor weakness (weakness, difficulty coordinating tongue, cheeks, lips, etc.)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Voice difficulties</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Difficulty swallowing</td>
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<td></td>
</tr>
</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. ____________________________
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-Ross MA, CCC/SLP/L
Consent for Clinical Services
Communicative Sciences and Disorders Clinic
CARVER COMPLEX RM 104

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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</thead>
<tbody>
<tr>
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</table>

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

Self/Guardian Signature ____________________________ Date ___________
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-Ross, Director of Clinical Services
P O Box 357
Normal, AL  35762
esther.ross@aamu.edu

Thank you for you 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)

Client/Guardian Signature: ___________________________________________  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
Alabama A & M University
Speech-Language-Hearing Clinic
REQUEST FOR CLINICAL SERVICES
*SUMMER 2019

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

<table>
<thead>
<tr>
<th>Preferred Option</th>
<th>Secondary Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday</td>
<td>Tuesday</td>
</tr>
<tr>
<td>9:00-9:50am</td>
<td>9:00-9:50am</td>
</tr>
<tr>
<td>10:00-10:50 am</td>
<td>10:00-10:50 am</td>
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<tr>
<td>11:00-11:50am</td>
<td>11:00-11:50am</td>
</tr>
<tr>
<td>1:00-1:50 pm</td>
<td>1:00-1:50 pm</td>
</tr>
<tr>
<td>2:00-2:50 pm</td>
<td>2:00-2:50 pm</td>
</tr>
</tbody>
</table>

 Thursday

9:00-9:50am    10:00-10:50 am
11:00-11:50am  1:00-1:50 pm
2:00-2:50 pm    

 Thursday

9:00-9:50am    10:00-10:50 am
11:00-11:50am  1:00-1:50 pm
2:00-2:50 pm    

I do not know my schedule for Summer ’19 (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 18th thru July 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 Summer ’19 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,

Mrs. Esther Phillips-Ross
Mrs. Esther Phillips-Ross MA,
CCC/SLP/L
Clinic Director
esther.ross@aamu.edu
AAMU Communicative Sciences and Disorders Clinic

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

Comments:
Speech-Language-Hearing Clinic
REQUEST FOR CLINICAL SERVICES
FALL 2019

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

Preferred Option

- __ I do not know my schedule for Fall ‘19 (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 16th thru November 28th. 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 ’19 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,

Mrs. Esther-Phillips-Ross
Mrs. Esther Phillips-Ross 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:
Alabama A & M University
Speech-Language-Hearing Clinic
REQUEST FOR CLINICAL SERVICES
SPRING 2020

Client's Name: ____________________________ DOB: ___________ Age: ___________
Spouse's/Parent's Name, if applicable: ____________________________
Email address: ____________________________________________________________
Address: ___________________________________________________________________________________________
City: ____________________________ State: ______ Zip: ____________________________
Phone number: home ___________ work ___________ other ___________
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

Prefer: Individual Therapy
Number of days per week you would prefer: 1 or 2

Secondary Option

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:50 am</td>
<td>9:00-9:50 am</td>
<td>9:00-9:50 am</td>
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<td>1:00-1:50 pm</td>
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<td>3:00-3:50 pm</td>
<td>4:00-4:50 pm</td>
<td>4:00-4:50 pm</td>
<td>4:00-4:50 pm</td>
</tr>
</tbody>
</table>

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 17th thru April 24th. 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 2020 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,

Mrs. Esther-Phillips-Ross
Mrs. Esther Phillips-Ross 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 2020

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

Preferred Option  Secondary Option
☐ Tuesday        ☐ Tuesday
  ❑ 9:00-9:50am  ❑ 9:00-9:50am
  ❑ 10:00-10:50 am ❑ 10:00-10:50 am
  ❑ 11:00-11:50am ❑ 11:00-11:50am
  ❑ 1:00-1:50 pm  ❑ 1:00-1:50 pm
  ❑ 2:00-2:50 pm  ❑ 2:00-2:50 pm

☐ Thursday       ☐ Thursday
  ❑ 9:00-9:50am  ❑ 9:00-9:50am
  ❑ 10:00-10:50 am ❑ 10:00-10:50 am
  ❑ 11:00-11:50am ❑ 11:00-11:50am
  ❑ 1:00-1:50 pm  ❑ 1:00-1:50 pm
  ❑ 2:00-2:50 pm  ❑ 2:00-2:50 pm

☐ I do not know my schedule for Summer ’20 (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 1st.**
The Clinic is tentatively scheduled to open June 16th 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 ’20 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,
Mrs. Esther Phillips-Ross
Mrs. Esther Phillips-Ross 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: