California University of Pennsylvania
The Learning and Language Center
California, Pennsylvania 15419
Phone # 724-938-4175
Fax # 724-938-1526

Application

Identifying Information:

Child's Name_____

(Last) (First) (Middle)

Address_____

Date of Application _____ Birthdate _____ Age _____ Phone ( ) _____

The CMD Learning and Language Center uses an inclusive model of instruction. Some children are typically developing. Some children have speech and/or language delays. Please indicate your child's communication and development:

[ ] My child has typical speech and language ability.
[ ] My child has a physical disability or concern.
[ ] My child has speech and/or language delays or concerns.
[ ] My child has a developmental disability.
[ ] Other (Explain: _____)

DO NOT WRITE IN THIS BOX – FOR DEPARTMENT USE ONLY

Father's Name _____

Address _____

Phone: Home _____ Work _____

Father's Occupation _____

Mother's Name _____

Address _____

Phone: Home _____ Work _____

Mother's Occupation _____

Siblings (name and age) _____

Guardian _____ Relation to child _____

Address _____

Phone: Home _____ Work _____

Referred by: _____

Are there speech or hearing concerns in the family? Yes _____ No _____
Describe:

Family Physician _____ Address _____

EARLY DEVELOPMENTAL HISTORY

At what age did the client or child do the following?

Lifted head: _____ Sat alone: _____ Sat with support: _____

Stood alone: _____ Stood with support: _____ Walked alone: _____

Walked with support: _____ Climbed steps: _____ Ran: _____

Babbled:_____ Said first word_____ Spoke in sentences_____

Toilet trained: _____ Dress self: _____ Prefer right/left hand: _____

Current weight: _____ Current height: _____

History of Illnesses (Please list.)

Frequent colds? Y N

Frequent ear infections? Y N

High Fever? Y N _____

Hospitalizations? Y N _____

Allergies: _____

Accidents (with dates): _____

Surgeries (with dates): _____

Estimate what percentage of the child's speech the following people understand:

Mother	_____%	Grandparents.	_____%
Father	_____%	Teachers	_____%
Siblings	_____%	Others	_____%

Are any of the following problems **CURRENTLY** present?

[ ] Sleeping Problems
[ ] Nervousness
[ ] High Activity Level
[ ] Too Trusting with Strangers
[ ] Tantrums
[ ] Low Activity Level
[ ] Health Problems
[ ] Nutritional Problems
[ ] Disciplinary Problems
[ ] Visual Problems
[ ] Learning delay or disability
[ ] Eating Problems
[ ] Unusual Fears
[ ] Difficulty Separating from Parent
[ ] Aggressiveness with other Children
[ ] Unhappiness
[ ] Too Shy/Timid with Others
[ ] Dental Problems
[ ] Attention Span
[ ] Chronic Conditions
[ ] Biting
[ ] Autism Spectrum Disorder

Comments: _____
_____

If your child has a communication delay or concern, answer these additional questions.

If a communication delay or concern is present, please describe it.

_____

Are there other concerns that you have for your child?
Comment: _____

Has the client received evaluations or therapy for this problem in the past? If so, from:

Whom? _____ Where? _____

When? _____
*** If you think that these records will be important to us, please bring copies of them with you.

BIRTH HISTORY

Pregnancy (length, etc.) _____ Age of mother at birth _____ Age of father at birth _____

Weight of child at birth _____ Length of child at birth _____

Unusual illness or condition _____

Any miscarriages or stillbirths _____ Types of delivery (normal, breech, etc.) _____

Early Problems (colic, feeding, etc.) _____

HEARING

Do you think the client has difficulty hearing? _____ Why? _____

When was the problem first noticed? ___ Has the client ever failed a hearing screening? ___

Is there a history of ear infection? ____ If yes, how often did the infection occur? _____

When was the last episode of ear infection? _____ Was ear drainage ever noticed? _____

How were ear infections treated? _____ Were tubes ever placed in the ears? _____

How many times? _____ By Whom? _____ Are tubes still in the ear(s)? _____

Have the tonsils and/or adenoids been removed? _____ Does your child wear hearing aid(s) _____

Parent/Guardian Signature: _____ Date: _____

Please direct any questions to our director, Dr. Sheri Lake- **lake_s@calu.edu**

PLEASE RETURN COMPLETED FORM TO: Kim Luckasevic- **luckasevic@calu.edu**