Northeastern University

Department of Communication Sciences & Disorders
Speech-Language and Hearing Center
503 Behrakis Health Science Center
Boston, MA 02115
(617) 373-2492

SOCIAL SKILLS GROUP – APPLICATION FORM

To be completed by parent/guardian and returned to the Center

Accepted students will be placed by age and social communication level. Homogenous groups are formed from applicants based on age, grade, social presentation and/or interests.

TODAY'S DATE: _____

CONTACT INFORMATION:		
Name of child:		**Pronouns:**
Home Address: Street: _____ City: _____ State: _____ Zip Code: _____		**Phone:** Home | Work | Cell _____ _____
Child's Date of Birth:	Age:	Grade:
Language Dominance:		
Other Languages Spoken:		
Parent/Guardian Name:		
Home Address: check here if same as above: ☐ Street: _____ City: _____ State: _____ Zip Code: _____		**Phone:** Home | Work | Cell _____ _____
Email:		

SOCIAL INTERACTIONS:		
Description of current social skills:		
1.	What are your child's social interaction strengths?	
2.	What are your child's social interaction difficulties?	
3.	What is your child's primary form of communication?	

Northeastern University

Department of Communication Sciences & Disorders
Speech-Language and Hearing Center
503 Behrakis Health Science Center
Boston, MA 02115
(617) 373-2492

RATING SCALE QUESTIONS:						
Please rate the following from 1 to 5 (1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good, 5 = Excellent)						
1.	Starting an interaction/conversation with a peer	1	2	3	4	5
2.	Maintaining an interaction/conversation with a peer	1	2	3	4	5
3.	Resolves social problems with discussion	1	2	3	4	5
4.	Is aware of other peers and seeks them out	1	2	3	4	5
5.	Responds to a peer's invitation to play/interact	1	2	3	4	5
6.	Understands non-verbal communication such as others' facial expressions, body language, tone of voice	1	2	3	4	5

GENERAL HEALTH INFORMATION:		
1. Describe your child's general health.		
2. Is your child currently under medical treatment or medication?		
3. Who is your family physician or pediatrician?		
Name: _____	Address:	
Phone: _____	Street:	
	City:	
	State:	
	Zip Code:	
4. List and describe any hospitalization, operations, or accidents.		
5. Please indicate if your child has had any of the following:		
☐ mumps	☐ convulsions	☐ fainting spells
☐ measles	☐ tuberculosis	☐ ear aches/infections
☐ chicken pox	☐ pneumonia	☐ allergies
☐ whooping cough	☐ frequent laryngitis	☐ meningitis
☐ scarlet fever	☐ tonsillitis	☐ freq. sore throat
☐ High fever	☐ frequent colds	☐ other:

Northeastern University

Department of Communication Sciences & Disorders
Speech-Language and Hearing Center
503 Behrakis Health Science Center
Boston, MA 02115
(617) 373-2492

6. Does anyone with biological ties to the child have a history of any of the following:	
Problem:	**Relationship:**
☐ speech, language problems	
☐ hearing problems	
☐ brain damage	
☐ mental retardation	
☐ cerebral palsy	
☐ emotional disturbance/mental illness	
☐ chronic illness (Please Specify Type:_____)	

CURRENT EDUCATION:		
1. Current grade level:		
2. Has your child repeated a grade? Y | N If so, which one?		
3. Is your child in a special class or receive special services?		
4. Is your child receiving tutoring in any subject area?		
6. What school does your child attend now?		
Name: _____	Street:	
Phone: _____	City:	
	State:	
	Zip Code:	
Principal's Name:	Teacher's Name:	
7. What is your child's attitude toward school?		
8. What is your child's favorite school subject or activity?		
9. What subject / activity does the child complain about the most?		
10. Is there anything else you would like to share?		

Thank you for your time to complete this application. Please email your completed form along with a current IEP, any evaluation reports and progress notes from other therapy to ***c.lywood@northeastern.edu*** *or print and mail to:*

Speech-Language and Hearing Center
503 Behrakis Health Sciences Center Attn: Claudia Lywood
30 Leon Street Boston, MA 02115