Northeastern University

SPEECH - LANGUAGE EVALUATION
ADULT CLIENT APPLICATION FORM
(Over 18 years)

TODAY'S DATE:

IDENTIFYING INFORMATION:

Name of person filling out this form:

Gender Identity and/or Pronouns:

Email address:

If different from above, name of person to be evaluated/client (referred to as "you" moving forward):

Pronouns:

Phone: Cell _____ Home _____ Work _____	Email: _____
Date of Birth:	Age:
Primary Language:	
Other languages spoken in the home:	

If under 21 and/or living with parent/guardian:

Parent/guardian #1 Name:	
Address: _____ _____ _____	Phone: Cell _____ Home _____ Work _____

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Parent/guardian #2 Name:	
Address: _____ _____ _____ ☐ Check if same as above	Phone: Cell _____ Home _____ Work _____

What cultural practices, rituals, or beliefs do you believe are important for us to be aware of?

STUDENT INFORMATION (IF APPLICABLE):

Local address (if different from previous page):	
College/University:	Year:
Major:	Do you have a job while in school? ☐ Yes ☐ No

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REASON FOR REFERRAL/REQUEST:

Who referred you?	Position/Relationship to you:
Reason for referral:	
Do you have any concerns about your communication? ☐ Yes ☐ No If yes, please describe:	
When and how did the communication challenge begin/first occur?	
Who was the first person to notice the difference in your communication?	
How would you rate the severity of the communication challenge now? ☐ Very mild ☐ Mild ☐ Moderate ☐ Moderately severe ☐ Severe	
Describe any changes that you have noticed regarding the above concern(s) since it began:	
Is communication more difficult at some times than at others? ☐ Yes ☐ No If yes, please explain:	
What is/are your current diagnosis/diagnoses?	

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Please check only those characteristics that are true of your speech NOW. This will aid in preparation for your evaluation.

Characteristic	**If checked, please describe:**
☐ Mispronounce or omit a sound or sounds while speaking	
☐ Difficulty recalling names of people, objects, etc.	
☐ Difficulty speaking in complete, well-organized sentences	
☐ Difficulty coordinating voice, tongue, lips, etc. to produce speech	
☐ Drooling while talking	
☐ Overly tense while talking	
☐ Stuttering (i.e., repetitions, blocks, or prolongations)	
☐ Voice sounds like it is coming through the nose	
☐ Voice always sounds like I have a cold	

Have you received a speech and language evaluation at another clinic?	☐ Yes	☐ No
If yes, please list the date of the evaluation:		
Name of Clinic:		
Have you received prior **Speech Therapy** services?	☐ Yes	☐ No
If yes, please list the most recent dates of service:		
Name of Clinic:	Therapist's Name:	
What was the focus of these services?		
What was most helpful with these services?		

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What was least helpful with these services?	
Have you received **ABA Therapy**? ☐ Yes ☐ No	
If yes, please list the most recent dates of service:	
Name of Clinic:	BCBA's Name:
What was most helpful with these services?	
What was least helpful with these services?	
Have you received **Occupational Therapy**? ☐ Yes ☐ No	
If yes, please list the most recent dates of service:	
Name of Clinic:	OT's Name:
What was most helpful with these services?	
What was least helpful with these services?	

Have you had a recent hearing screening or evaluation? ☐ Yes ☐ No	
When?	Where?
Do you ever hear noises (ringing, buzzing, roaring, etc.) in your ears? ☐ Yes ☐ No	
Have you been exposed to loud sounds (gunfire, heavy machinery, etc.)? ☐ Yes ☐ No	
☐ Hearing loss in one/both ear(s) ☐ right ☐ left	
☐ Can hear but do not understand when people talk to me	
☐ Prefer having the television turned louder than those around me	

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☐ Difficulty hearing in a one-to-one situation
☐ Difficulty hearing in groups
☐ Difficulty hearing on the telephone
☐ No difficulty hearing
Have you ever worn a hearing aid? ☐ Yes ☐ No If yes, when?
Do you wear a hearing aid now? ☐ Yes ☐ No If yes, approximately when was it purchased? Make and Model number: Hearing Aid Dealer:
Does the aid seem to be operating properly at this time? ☐ Yes ☐ No

Does anyone in the family have a history of the following:	
Area of Concern	**Relationship to You**
☐ Speech and Language	
☐ Autism	
☐ Hearing	
☐ Traumatic Brain Injury/Concussion	
☐ Intellectual Disability	
☐ Cerebral Palsy	
☐ Mental Health	
☐ Chronic Illness	

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If applicable, please indicate the brand and model number of wheelchair(s):

Brand:	Model:
Brand:	Model:

HEALTH RECORD:

Describe your general health:	
Are you currently taking medication? ☐ Yes ☐ No If yes, please list medication(s) below:	

Who is your primary care physician or ear-nose-throat (ENT) specialist?	
Name:	Phone:
Address:	Fax:

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List and describe any hospitalization, operations, or accidents within the last ten years (indicate age at time of occurrence).	
Event	**Age**
Do you have any specific medical needs we should know about (e.g., allergies, asthma, seizures) Please list:	

Have you ever had a neurological or neuropsychological evaluation? If yes, please complete the following section.	☐ Yes ☐ No
Type of evaluation:	Date of evaluation:
Name of clinic or hospital:	Address:
Are you currently receiving counseling?	☐ Yes ☐ No

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Please indicate if you seek or avoid the following (if neither, please leave row blank):		
	Seeks	**Avoids**
Visual (e.g., bright colors, contrast colors, lights on/off/dimmed)	☐	☐
Tactile (e.g., alerted/calmed by touch/avoid or seek textures)	☐	☐
Gustatory/oral (e.g., seeks out intense flavors, crunchy foods, puts objects in mouth)	☐	☐
Vestibular (e.g., swinging, spinning, bending upside down is calming/overwhelming)	☐	☐
Proprioceptive (e.g., crashes into pillows/people, seeks climbing, jumping)	☐	☐
Auditory (e.g., puts hands over ears, enjoys music/musical toys)	☐	☐

May we have your permission to request information about the evaluation and/or therapy mentioned above to assist us in our evaluation of your present communication challenge? ☐ Yes ☐ No

If yes, please fill out one of the attached "AUTHORIZATION FOR RELEASE OF INFORMATION" forms. If the evaluation and therapy took place in more than one place, please fill out one form for each setting.

Are there any limitations on your schedule that would make it impossible for you to come for an evaluation on any specific day? ☐ Yes ☐ No If yes, please describe:

If you have any other information which you feel would be helpful to us in preparing for your evaluation, please write it in the space provided here.

Thank you for your time in filling out this form!

Please email your completed form to SLHC@northeastern.edu, or print and mail to:

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