SOCIAL SKILLS GROUP – APPLICATION FORM

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

TODAY'S DATE:

IDENTIFYING INFORMATION:

Name of child: **Gender Identity and/or Pronouns:**	
Date of Birth:	Age:
Primary Language:	
Other languages spoken in the home:	
Who should be contacted to schedule an appointment?	

Parent/guardian #1 Name:	
Address: ______________________ ______________________ ______________________	Phone: Cell Home ______________ Work ______________
Email:	

Parent/guardian #2 Name:	
Address: ______________________ ______________________ ______________________ Check if same as above	Phone: Cell ______________ Home ______________ Work ______________
Email:	

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

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

REASON FOR APPLICATION:

Please describe your child's current social behavior:	
How does your child interact in a small/large group of peers?	
Does your child have a friend?	
Who was the first person to notice concerns with your child's social skills?	
Is your child aware of their challenges/does your child have any concerns about their social skills?	
Please describe any past social skills work your child has completed:	
Is your child highly sensitive to certain sensory inputs (e.g., sounds, textures, lights)? If so, please explain:	

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

BACKGROUND:

Has the child had a recent hearing screening or evaluation? Yes No	
When?	Where?
Does the child ever hear noises (ringing, buzzing, roaring, etc.) in your ears? Yes No	
Has the child been exposed to loud sounds (gunfire, heavy machinery, etc.)? Yes No	
Hearing loss in one/both ear(s) right left both	
Can hear, but not understand when people talk to me	
Prefer having the television turned louder than those around me	
Difficulty hearing in a one-to-one situation	
Difficulty hearing in groups	
Difficulty hearing on the telephone	
No difficulty hearing	
Has the child ever worn a hearing aid? Yes No If yes, when?	
Does the client 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	

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

CURRENT EDUCATION:

Current grade level:	
Has your child repeated a grade? Yes No If so, which one?	
Is your child in a special education class or do they receive special services?	
Is your child receiving tutoring in any subject area?	
What school does your child attend now?	
Name: ________________________	**Street:**
	City:
Phone: ________________________	**State:**
	Zip Code:
Teacher's Name:	
What is your child's attitude toward school?	
What is your child's favorite school subject or activity?	
What subject / activity does the child complain about the most?	
Is there anything else you would like to share?	

Thank you for your time to complete this application.

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

Speech-Language and Hearing Center
Northeastern University
360 Huntington Ave
503 Behrakis Health Sciences Center
Boston, MA 02115