Speech Pathology and Audiology will provide intensive intervention focusing on Articulation, Fluency, and Language for qualified applicants, ages 5-13. Five year olds must have completed kindergarten. There is no cost. If on the Department’s website, scroll down for an application or it can be downloaded at www.tnstate.edu/speechpath and submitted along with any prior diagnostic and treatment reports, IEP’s, and other pertinent data, to the following address:

Speech Camp
Department of Speech Pathology and Audiology
330 10th Ave. North, Suite N200
Nashville, TN 37203

Applications must be postmarked on or before April 18, 2014

Scheduled Diagnostics: June 10th through 12th
Full Camp Dates: June 16th through July 10th
Time: Monday through Thursday, 8:30 am – 4:30 pm

Articulation Camp
Treatment of speech sounds

Fluency Camp
Treatment of stuttering

Language Camp
Treatment of receptive and expressive language

Diagnostic Camp
Comprehensive Assessments

Dates and times are subject to change

Contact Persons:
Tyese Hunter @ 963-7010 or Clara Tharpe @ 615-963-7072
Emails: THunter4@tnstate.edu  _CTharpe@tnstate.edu

Tennessee State University: A Tennessee Board of regents Institution. TSU is an equal opportunity, affirmative action institution committed to educating a non-racially identifiable student body. In accordance with the American with Disabilities Act, persons who need assistance with this material may contact the Department of Speech Pathology & Audiology at (615) 963-7087 or (615) 963-7081.
TENNESSEE STATE UNIVERSITY
Speech, Language, and Hearing Clinic

PATIENT INTAKE FORM

FILE # _________

PATIENT’S FULL NAME: ____________________________ Circle: Adult / Child
FATHER’S NAME: ______________ MOTHER’S NAME: ______________
ADDRESS: ____________________________________________

TELEPHONE: Home __________ Work ____________ Cell __________

DATE OF BIRTH: __________ AGE: ______ MALE: _____ FEMALE: __
PRIOR SPEECH SERVICES RECEIVED (When) __________ (Where) __________
CLIENT WILL RETURN FOR _____ Summer _______ Fall ________ Spring Session
PROBLEM DESCRIPTION: ____________________________________________

________________________________________________________________________

REFERRED BY: __________________________________________ DATE: _____

******TO BE FILLED OUT BY CLINICAL STAFF******

INITIAL VISIT IS SCHEDULED FOR: __________ Time: ___________AM/PM

SPEECH:
Diagnostic ______________________ Therapy ______________________

AUDIOLOGY:
Diagnostic ______________________ Rehabilitation ______________
Clinician: ______________________ Supervisor: ______________________
Referral Source: ________________________________
PERSONAL HISTORY-CHILD

Note: Please complete this form and return to the above address. Include Department of Speech Pathology and Audiology

Date:__________________________

I. GENERAL INFORMATION

Child’s Full Name__________________________________________________
Current Age__________________           Birthdate________________________
Sex:       M(       ) F(        )

Address:__________________________________________________________
                                      Street       City       State       Zip Code

Phone#:______________________________________
Mother’s full name:__________________________________________________
Age________________ Education completed:____________________________
Residence:________________________________________________________

Daytime Phone #________________________________
Father’s full name:______________________________________________
Age________________ Education completed:____________________________
Residence:________________________________________________________

Daytime Phone #________________________________
List all persons living in the home:
Name                                                                 Age          Relationship
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Family Physician___________________________________________________
Pediatrician_______________________________________________________
I believe my child has difficulty with:

- _____ speech (articulation)
- _____ language
- _____ voice
- _____ fluency
- _____ hearing
- _____ other ____________________________

Describe the problem in detail (Use back of sheet if needed):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What do you think caused the problem? _________________________________

What has been done to correct it? _________________________________

How does the child seem to feel about his/her problem? ________________________________

Does any other family member have a speech or hearing problem? ______
(If yes, state nature of problem and relationship to child) ________________________________

II. EARLY HISTORY

Health of mother during pregnancy ________________________________

Diseases, accidents, drugs, x-ray treatment of mother during pregnancy __________

Exposure to any infectious diseases during pregnancy ________________________________

Which pregnancy was this child? __________ Full term? ___________

Length of labor? __________ Was delivery normal? __________________

Child’s weight and condition at birth ________________________________

Describe any birth problems ________________________________

Was child’s development normal for sitting, standing, walking, etc.? ______

Describe any health or feeding problems during early childhood __________________

________________________________________________________________________
III. LANGUAGE DEVELOPMENT (List ages carefully. This is very important.)

When did child begin to babble or coo?______________________________
When did child speak first words?_________________ Sentences________
How does the child make his wants known?__________________________

Was there anything different about the way the child made sounds, noises, words, etc., during the first two years?____ Explain. (Preferred to point or gesture; started talking and then stopped, etc.)____________________________

When was the problem first noticed?_________ By whom?_________________
Has the child’s speech changed recently?______________________________
What does the child do when his speech is corrected?____________________
Does the child repeat your questions instead of answering them?__________

IV. HEARING (Complete if you think your child has a hearing problem)

What makes you think your child has a hearing problem?_________________

How old was the child when you realized there was a hearing problem?_______
Does he pick or pull his/her ears?____________
Does your child wear hearing aids?________
Left Ear____Right Ear____Both Ears_____

V. HEALTH HISTORY (Give age and severity of following illnesses your child has had).

<table>
<thead>
<tr>
<th>Illness</th>
<th>Age</th>
<th>Describe Illness</th>
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</thead>
<tbody>
<tr>
<td>Measles</td>
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<tr>
<td>Mumps</td>
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<td>Chicken Pox</td>
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<td>Tonsillitis</td>
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<td>Ear Infections</td>
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<td>Fainting</td>
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<td>Seizures</td>
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<td>Diabetes</td>
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<td>High Fever</td>
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<td>Visual</td>
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<td>Asthma</td>
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<td>Frequent Colds</td>
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<td>Thyroid Trouble</td>
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<tr>
<td>Paralysis</td>
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<tr>
<td>Heart condition</td>
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<tr>
<td>Other</td>
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</tr>
</tbody>
</table>
What operations and/or serious accidents has the child had? (include dates)____
________________________________________________________________________

What medication, if any, does the child receive?________________________
________________________________________________________________________

Is the child clumsy?_______ Explain________________________________________

SCHOOL
Current School ________________________ Address_____________________
________________________________________________________________________

Grade__________ Teacher________________________________________
What is the child’s attitude toward school?______________________________
Describe any school difficulties (reading, writing, etc.)_____________________
________________________________________________________________________

Has the child ever had an intelligence test?_______ Explain___________________
________________________________________________________________________

VI. EMOTIONAL ADJUSTMENT AND PERSONAL CHARACTERISTICS

How would you describe the child’s personality?__________________________
How does the child respond to people?___________________________________
Is the child hard to manage?___________________________________________
Does the child sleep and eat well?_______________________________________
How is the child punished?_____________________________________________
Has the child ever experienced a severe shock or fright?___________________
If so, explain__________________________________________________________

*Notes:

1. It is very likely that your child’s session/s will be observed by students enrolled in Speech Pathology or Audiology courses.

2. It is our policy to terminate clients who are absent from therapy for 3 consecutive sessions without prior notification from the client to the Clinical Coordinator or Supervisor.
Client/ Family Responsibilities

1. The client must be on time and prepared for camp.
2. If a client is greater than 25 minutes late for camp, that day will be cancelled and considered an absence. Excessive tardiness can result in dismissal from camp.
3. If a client or parent cancels a session due to illness or other conflicts, please contact your primary clinical supervisor before 8:00 a.m., the day of the session, at _________ or the clinic secretary at 963-7072.
4. You have the right to request a meeting with the clinical supervisor or the clinician with the supervisor present. However, we do request that you allow at least 48 hours advance notice.
5. You have the right to review your chart and or your child’s chart. However, we request a 48 hour notice.
6. If the client misses 2 consecutive sessions they may be dismissed from camp.
7. We reserve the right to discharge and refer a client to other service providers for valid reasons.
8. You have the right to observe your child but not to disrupt the treatment process.
9. Parents/legal guardian must be in attendance the first day of camp to sign all consent and release forms.
10. The parents/caregiver must sign in each day and sign out each day. No minor child shall be left or dropped off or picked up without signing in/out. No minor child shall be allowed to exit the suite without parental/caregiver supervision.
11. Our clinic is part of a university training program; student clinicians and clinical supervisors are changed based on academic and practicum requirements each semester.

Signature (If under 18 years of age parent/guardian)  Date

__________________________________________  __________________________
Student Clinician                              Clinical Supervisor

ORIGINAL TO FILE AND COPY TO PARENT/CLIENT
AUTHORIZED TO RELEASE INFORMATION

I, ______________________________________________________________________

The parent(s) and/or legal guardian(s) of ______________________________________________________________________ do hereby grant permission to: (Sending Agency or Individual Name and Address)

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

to provide the below requested information to Tennessee State University Speech, Hearing and Language Clinic, Nashville, TN.

( ) Diagnostic Evaluation Reports

( ) Speech Therapy Progress Notes, I.E.P./I.F.S.P. Reports & Summary Reports

( ) Discharge Reports

( ) History and Physical Reports

( ) X-Ray, CT Scan, or MRI Reports

I, ______________________________________________________________________, by this same document give permission to Tennessee State University Speech, Hearing, and Language Development Center to provide above requested information to: (Receiving Agency or Individual Name and Address)

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Parent’s Signature:__________________________

Date:____________________________________

Witness:__________________________
AGREEMENT AND CONSENT FOR EMAIL AND PHONE

Patient’s Name: _____________________________

Parent’s or Guardian’s Name:  __________________________________

I do_______ do not________ give my permission for the Tennessee State University Speech Pathology and Audiology Clinic to contact me via the email that I have provided.

Email __________________________________________________

I do_______ do not________ give my permission for the Tennessee State University Speech Pathology and Audiology Clinic to leave a recorded message on the phone numbers that I have provided.

Telephone Number: __________________________________________

I do_______ do not________ give my permission for the Tennessee State University Speech Pathology and Audiology Clinic to leave a verbal message with a friend or family member that may answer at one of the phone numbers that I have provided.

I prefer that information ONLY be mailed to me at the address below be marked CONFIDENTIAL

_________________________________________________

Signature (if under 18 years of age, parent/guardian) ___________________________ Witness Name ___________________________

Date ___________________________ Date ___________________________