Thank you for your interest in the SUNY New Paltz Speech and Hearing Center. We provide a wide variety of services for people with communication disorders with the community and at New Paltz College. Below is a list of some of our services and fees. We believe that we provide a high level of quality care at our Center. Our fees may be significantly lower than private Speech and Hearing Centers and Hospital programs because we are a training institution. Each of our students benefits from every client that we evaluate. Certain services are available to college students, faculty, and staff at no charge. All of the services outlined are strictly supervised by NYS licensed, ASHA certified professionals.

REFERRALS

Referrals may be made by any interested person (parents, teachers, physicians, dentists, psychologists, counselors, self).

DIAGNOSTIC SPEECH AND LANGUAGE EVALUATIONS ($75)

A detailed examination of an individual's speech and language function including interview, case history, and summary consultation with the client or parent. Recommendations may include referral to other professional(s), and therapy. These evaluations are performed by appointment only.

THERAPY SERVICES ($240.-FALL AND SPRING; $120.- SUMMER)

Speech and language therapy is available for preschool and school age children, New Paltz College students and adults.

Audiological services may include diagnostic hearing evaluations, referrals, hearing aid evaluations, dispensing and repairs. These services are available to New Paltz students, faculty and staff, preschool and school-age children, and individuals in the surrounding community.

\[
\text{Hearing Evaluation: } \$65. \\
\text{Hearing Aid Evaluation: } \$35. \\
\]

\text{Hearing Aid Fitting Fees (dependent upon manufacturer's invoicing) Earmolds: } \$35. \\

* The total cost of the hearing aid purchased through our Center is determined by the manufacturer's cost plus a fitting fee. The fitting fee is determined by the size of the hearing aid required.
Your child has been scheduled to receive a speech and language examination. In preparation for this examination, we would like you to provide us with the following information. This information will assist the staff in planning for and conducting a more meaningful examination.

Please answer the questions as fully and as accurately as possible. Many parents have found the child's baby book helpful in remembering particular dates and information. If you are not sure of a particular date, would you please write the date that you think is right and put a question mark after it. Your family physician may also be able to provide you with certain information or could send it directly to us if you request it.

Please return this form to:  
SUNY New Paltz  
Speech, Language and Hearing Center  
Humanities Building  
1 Hawk Drive  
New Paltz, New York 12561-2443

Please complete this form as soon as possible to allow our staff sufficient time to review the information before seeing your child.

All the following information is for the confidential use of the Speech, Language and Hearing Center staff only.

DESCRIPTION OF THE SPEECH PROBLEM:

Describe, in your own words, your child's speech problem. You may continue your description on the back of this sheet.

Thank you,

Speech, Language and Hearing Center Staff

Date: ______________
GENERAL INFORMATION:

Name: ___________________________ Birthdate: __________ Age: ___ Sex: _____

Address: ____________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
Telephone: ___________________ Birthplace: ______________________________________________________

Name of school child attends: __________________________________________________________________

Educational Level: _____________________________________________________________________________

Person, professional, or agency who referred you to the center: __________________________________________
_____________________________________________________________________________________________

Person filling out this form: ______________________________________________________________________

PERSONAL AND FAMILY HISTORY:

Mother: _____________________________ Telephone Number: (____) __________

Address: ______________________________________________________________________________
_____________________________________________________________________________________

Occupation: _______________________________________________________________________________

Business Telephone Number: __________________________________________________________________

Education: _______________________________________________________________________________

Language(s) spoken: _________________________________________________________________________

Father: _____________________________ Telephone Number: (____) __________

Address: ______________________________________________________________________________
_____________________________________________________________________________________

Occupation: _______________________________________________________________________________

Business Telephone Number: __________________________________________________________________

Education: _______________________________________________________________________________

Language(s) spoken: _________________________________________________________________________

Step-parent:_________________________ Telephone Number: (____) __________

Address: ______________________________________________________________________________
_____________________________________________________________________________________

Occupation: _______________________________________________________________________________

Business Telephone Number: __________________________________________________________________
Education: _____________________________________________________________

Language(s) spoken: _____________________________________________________________________________

Are any other languages spoken in the household? Yes ___ No ___
If "yes", explain: _______________________________________________________________________________

Other children living in the home:
Name                                      Age                                      School/Grade or Employment

Other persons living in the home:
Name                                      Relationship

Are there any family members with speech, hearing, or reading/learning problems? Yes ___ No ___
If "yes", explain: _______________________________________________________________________________

PRENATAL AND BIRTH HISTORY:

Number of pregnancies prior to this child ____
Length of pregnancy for this child ______
During this pregnancy, did mother experience any unusual illnesses, conditions or accidents such as: German measles, false labor, RH incompatibility, etc. If so, please describe: ______________________________________
_____________________________________________________________________________________________

Duration of labor ____ Birth weight ________ Length at birth _________

Name and address of the attending physician(s): ______________________________________________________
_____________________________________________________________________________________________

Conditions at birth: Caesarean ___ Breech ___ Anesthetics ___ Forceps ____

Was infant blue? ____ Jaundiced? ____ Scars or bruises: ____________________________________________

Other conditions: _______________________________________________________________________________
_____________________________________________________________________________________________
DEVELOPMENTAL HISTORY:

Conditions of the child immediately following birth:
   Any feeding problems ____
   Seizures ____
   Swallowing problems ____
Was birth weight quickly regained? ____
Ages of occurrences and possible caused of any sudden gains or losses of weight:

When did the child:
   hold up the head alone ____
   first crawl ____
   sit alone without support ____
   pull him/herself to a standing position ____
   cut first tooth ____
   walk unaided ____
   first feed self with a spoon ____
   first gain control of bowel ____ bladder ____

Weight at six months ____ Height at six months ____
Weight at twelve months ____ Height at twelve months ____
Weight of child at present ____ Height at present ____
Age at which one hand was used for doing most things ____ Which hand was primarily used ____
Would you say your child's general development up to the age of three years has been rapid, average, or slow? ____

Is balance a problem for your child? ____
Does he/she seem to control his/her body with ease? ____
At present, does your child have difficulties chewing or swallowing? ____
Is your child fairly active ____ active ____ very active ____?

MEDICAL HISTORY:

Check diseases child has had, giving age, degree of severity, and after-affects. Please add other diseases the child has had which are not listed.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Age</th>
<th>Severity</th>
<th>Disease</th>
<th>Age</th>
<th>Severity</th>
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<tbody>
<tr>
<td>Measles (type)</td>
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<td>Croup</td>
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<td>Diphtheria</td>
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<td>Pleurisy</td>
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<td>Chicken Pox</td>
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<td>Tonsilitis</td>
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<td>Typhoid</td>
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<td>Tuberculosis</td>
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<td>Mumps</td>
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<td>Bronchitis</td>
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<td>Dysentery</td>
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<td>Otitis (Ear Ache)</td>
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<td>Whooping cough</td>
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<td>Goiter</td>
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<td>Influenza</td>
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<td>Rickets</td>
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<td>Scarlet fever</td>
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<td>Paralysis</td>
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<td>Enlarged glands</td>
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<td>Nervous troubles</td>
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<tr>
<td>Rheumatism</td>
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<td>Chorea (St. Vitus)</td>
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<td>Heart disease</td>
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<td>Kidney disease</td>
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<td>Convulsions</td>
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<td>Skin disease</td>
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<td>Asthma</td>
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<td>Hay fever</td>
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<tr>
<td>Eczema</td>
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<td>High fevers</td>
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<td>Frequent colds</td>
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<td>Allergies</td>
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<td>Menningitis</td>
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<td>Encephalitis</td>
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</tbody>
</table>
Other diseases of note: 
_____________________________________________________________________________________________

Has the child had any serious accidents or operations? Please describe:
_____________________________________________________________________________________________

 Were the tonsils and/or adenoids removed? ___ At what age? ___
Describe any after-affects of illnesses, accidents, operations: ________________________________
_____________________________________________________________________________________________

 Does the child have a visual or hearing problem? ___ Describe: _________________________________
_____________________________________________________________________________________________

 Does the child have any physical disabilities? ___ Describe: _________________________________
_____________________________________________________________________________________________

 Family health: (Note any incidences within the immediate family)

Deafness ____________________________________________________________
Epilepsy ____________________________________________________________
Cerebral palsy _______________________________________________________
Mental illness ________________________________________________________
Mental retardation ____________________________________________________

 SPEECH AND LANGUAGE DEVELOPMENT:

During the first year, did your child make sounds other than crying? _____________________________
Describe: ________________________________________________________________________________

Other than crying, would you say your child was a silent baby ___ a very quiet baby ___ an average noisy baby ___ or a very noisy baby ___.

At what age did your child first say words? _____ What were some of these words?
________________________________________________________________________________________

 Did your child show a steady growth of useful words? ___ Describe: ______________________________
________________________________________________________________________________________

 At what age did your child use names of people and objects? _________________________________

When did your child combine words into small, meaningful sentences such as "Want drink." or "Me, out." ______
When did your child use more complete short sentences? ________________________________
Did your child's speech learning ever seem to stop for a period? _________________________________________
Describe: ______________________________________________________________________________________
____________________________________________________________________________________________

Does your child seem to be aware of his/her speech difference? _________________________________________
Describe: ______________________________________________________________________________________
____________________________________________________________________________________________

What efforts have been make to help your child talk better? _____________________________________________
____________________________________________________________________________________________

Have there been changes in the child's speech in the last six months? ______________________________________
Describe: ______________________________________________________________________________________

Has your child ever talked better than he/she does now? ___ Describe: __________________________________________________________________________
____________________________________________________________________________________________

When and by whom was the child's speech problem first noticed? ________________________________________
____________________________________________________________________________________________

Is the child teased about his speech problem? ________________________________________________________
____________________________________________________________________________________________

Has your child had a speech evaluation prior to this time? ____ Where, when, by whom
____________________________________________________________________________________________
____________________________________________________________________________________________

Has your child ever had speech therapy? ____ Where and by whom ________________________________
____________________________________________________________________________________________

Does the child receive speech therapy at this time? ____ Where and by whom _________________________
____________________________________________________________________________________________

Has the child had a hearing test prior to this time? ____ Where, when, and by whom
____________________________________________________________________________________________

Has the child had a psychological evaluation prior to this time? _________________________________
Where, when, and by whom ______________________________________________________________________

Has your child had a recent medical examination? ____ Where, when, and by whom ______________________________________________________________________

If your child has had any of the above examinations or evaluations, it would be helpful to the Speech and Hearing Center if you would contact the persons who examined your child and ask them to send or fax copies of their findings to:

SUNY New Paltz
Speech, Language and Hearing Center
Humanities Building
1 Hawk Drive
New Paltz, New York 12561-2443
Telephone: (845) 257-3600
Fax: (845) 257-3605

SOCIAL HISTORY:

Does your child show fears: often ___ sometimes ___ seldom ___? What things does he/she fear?

_____________________________________________________________________________________________

Is your child "nervous?" ____ How does he/she show it?

_____________________________________________________________________________________________

Describe how your child gets along with others:

_____________________________________________________________________________________________

Describe his/her play

_____________________________________________________________________________________________

Describe his/her sleep habits (hours of nightly sleep, naps, nightmares, bed wetter etc.)

_____________________________________________________________________________________________

Does your child bite his/her nails? ____ suck the thumb or fingers? ____

Has your child been easier, the same, or more difficult to manage than other children?

_____________________________________________________________________________________________

What types of discipline are most useful and effective?

_____________________________________________________________________________________________

Is your child a leader or follower in his/her age group?

_____________________________________________________________________________________________

Describe any eating problems

_____________________________________________________________________________________________
SCHOOL HISTORY:
What school(s) has your child attended: _____________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Describe your child's school experiences (Pre-school, elementary school, high school) _____________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

It would be helpful to the Speech and Hearing Center if you would contact the school(s) your child has attended and ask them to send or fax copies of your child's records to:

SUNY New Paltz
Speech, Language and Hearing Center
Humanities Building
1 Hawk Drive
New Paltz, New York 12561-2443
Telephone: (845) 257-3600
Fax: (845) 257-3605

IF THERE IS ADDITIONAL INFORMATION WHICH YOU BELIEVE WILL HELP US TO UNDERSTAND YOUR CHILD BETTER, PLEASE DESCRIBE BELOW:

If you wish to contact our program to make an appointment for an evaluation or to schedule speech and language therapy services, please contact us at (845) 257-3600. We will forward these forms to you, parking information and a parking permit.
DIRECTIONS TO SUNY NEW PALTZ—
HUMANITIES BUILDING

From the North or South, take the NYS Thruway (I-87) to Exit 18. Turn left onto Route 299 and proceed approximately 6 miles to New Paltz. Turn left onto South Manheim Boulevard (Route 32 South).

From the Northeast/West, take the NYS Thruway (I-90) to Albany and then south (I-87) to Exit 18. Turn left onto Route 299 and proceed approximately 6 miles to New Paltz. Turn left onto South Manheim Boulevard (Route 32 South).

From the Southwest, take Route 17 east to the NYS Thruway (I-87) and north on the Thruway to Exit 18. Turn left onto Route 299 and proceed approximately 6 miles to New Paltz. Turn left onto South Manheim Boulevard (Route 32 South).

From Connecticut, take I-84 west to Exit 7S and follow the signs for the NYS Thruway (I-87). Take the Thruway north to Exit 18. Turn left onto Route 299 and proceed approximately 6 miles to New Paltz. Turn left onto South Manheim Boulevard (Route 32 South).

From New Jersey, take the Garden State Parkway north or Route 17 north to the NYS Thruway (I-87) to Exit 18. Turn left onto Route 299 and proceed approximately 6 miles to New Paltz. Turn left onto South Manheim Boulevard (Route 32 South).

From the Mid-Hudson Bridge, after you pass the toll booth (no toll is collected in this direction), take the first exit which is Route 9W North. Proceed 2 ¾ miles to a traffic light at the intersection of Route 299. Turn left onto Route 299 and proceed approximately 6 miles to New Paltz. Turn left onto South Manheim Boulevard (Route 32 South).