

THE UNIVERSITY OF SOUTHERN MISSISSIPPI
SPEECH AND HEARING CLINIC
SEMESTER PROGRESS REPORT

DATE _____

CLINIC NUMBER _____

NAME _____ DATE OF BIRTH _____ C.A. _____

ADDRESS _____ PARENTS _____

TYPE OF DISORDER _____ THERAPY _____

NUMBER OR PREVIOUS SEMESTERS OF THERAPY _____

NO. OF THERAPY SESSIONS SCHEDULED THIS TERM _____

NO. OF THERAPY SESSIONS ATTENDED THIS TERM _____

DISPOSITION _____

CLINICIAN _____

STATUS AT THE BEGINNING OF THE SEMESTER _____

THERAPY GOALS

ADDITIONAL INFORMATION

CHANGES IN STATUS

PROGNOSIS

RECOMMENDATIONS

_____, Graduate Clinician

APPROVED BY _____
Supervisor Date