SAN JOSÉ STATE UNIVERSITY

Kay Armstead Center for Communication Disorders
Connie L. Lurie College of Education · Department of Communicative Disorders and Sciences
One Washington Square · San José, CA 95192-0079 · Main: (408) 924-3679 · Fax: (408) 924-3641

COUNCIL ON ACADEMIC ACCREDITATION
ACCREDITED | SPEECH-LANGUAGE PATHOLOGY

ADULT SPEECH & LANGUAGE EVALUATION APPLICATION (2 PAGES)

Attach **ANY** recent reports from doctors, other speech therapists, and/or therapy providers.

Date Received: **OFFICE USE ONLY**

CLIENT INFORMATION

Name: _____ Date of Application: _____
LAST NAME FIRST NAME MIDDLE NAME DAY / MONTH / YEAR

Date of Birth: _____ Place of Birth: _____ Age: _____ Gender: _____
DAY / MONTH / YEAR COUNTRY, CITY, STATE MALE / FEMALE

Address: _____ _____ _____ _____
STREET NUMBER & NAME CITY STATE ZIP

Home #: (_____) _____ - _____ Mobile #: (_____) _____ - _____ Work #: (_____) _____ - _____

Email: _____

Presenting Problem (Why is an evaluation being requested?)

CLIENT REFERENCE INFORMATION

Who referred you to the KACCD clinic? _____
What language(s) do you speak? _____
What is your primary language? _____ Secondary language? _____
If applicable, what percent of the day is your primary language spoken? ☐ n/a or _____ %
If applicable, what percent of the day is your secondary language spoken? ☐ n/a or _____ %

CLIENT QUESTIONNAIRE

What do you feel is the problem with your speech skills? (Include language, voice, fluency, swallowing, thinking, social, and/or hearing skills.)

What do you feel has caused the problem(s)?

When did you first notice the problem(s)?

What are some situations that exacerbate the problem(s)? (i.e. during confrontations, at restaurants, etc. Please describe specific situations.)

CLIENT QUESTIONNAIRE (CONT.)

How does this problem handicap you in everyday life?

Please provide additional information that may have a bearing on your communication problem.

MEDICAL HISTORY

Doctor Name: _____ Phone: (____) ____ - _____

Hospital Name: _____ Phone: (____) ____ - _____

_____ _____ _____ _____

HOSPITAL ADDRESS CITY STATE ZIP

Have you had any significant illnesses, accidents or surgeries? ☐ Yes ☐ No

If yes, please include detailed explanations and dates of all hospitalizations, injuries, and traumas, etc.

Do you take any medication? ☐ Yes ☐ No (If yes, please list each medications and the reason for taking each below.)

You suffer from: ☐ seizures ☐ convulsions ☐ frequent fainting ☐ other: _____ ☐ n/a

If applicable, please explain:

Do you have normal hearing? ☐ Yes ☐ No

Have you had a hearing evaluation? ☐ Yes ☐ No (If yes, please complete section below)

Location: _____ Date: _____ Examiner Name: _____

Findings and recommendations:

Have others suggested that you do not hear normally? ☐ Yes ☐ No (If yes, please explain below)

Do you have allergies? ☐ Yes ☐ No (If yes, please list the allergies below.)

Please indicate which devices you use: (select all that apply)

☐ Glasses ☐ Hearing Aids ☐ Walker ☐ Wheelchair ☐ Orthodontics

Other(s): _____

NAME OF THE PERSON WHO COMPLETED THIS FORM (IF OTHER THAN CLIENT): _____

When you have completed filling out this application (and have attached the appropriate documents) please return, mail or fax it via the information provided on page one. Our office will contact you to schedule an assessment once your application has been