SJSU SAN JOSÉ STATE UNIVERSITY

Connie L. Lurie College of Education
Communicative Disorders and Sciences

www.sjsu.edu/cds

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Kay Armstead Center for
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COUNCIL ON ACADEMIC ACCREDITATION
ACCREDITED - SPEECH-LANGUAGE PATHOLOGY

The California State University:
Chancellor's Office
Bakersfield, Channel Islands, Chico, Dominguez Hills,
East Bay, Fresno, Fullerton, Humboldt, Long Beach,
Los Angeles, Maritime Academy, Monterey Bay,
Northridge, Pomona, Sacramento, San Bernardino,
San Diego, San Francisco, San José, San Luis Obispo,
San Marcos, Sonoma, Stanislaus

Dear Prospective Client/Family,

Thank you for your interest in our center. At the Kay Armstead Center for Communication Disorders, we serve all ages across a wide variety of disabilities, as well as accent modification.

Our therapy rates vary by semester, and are based on the academic schedule. Please contact us for current rates for both assessments and therapy. Our fees can be paid up front or in monthly installments.

It is our goal to establish a mutually valuable relationship that benefits both our clients and student clinicians. As we operate a premiere training institution, students come to us from a variety of cultural and linguistic backgrounds. They are supervised by experienced speech-language pathologists, and our students are prepared to provide you or your loved one with excellent clinical services.

Please note that we are a training center and these clinics operate as coursework for our students. The clinic follows the SJSU academic semester schedule, which means we are limited with regard to specific dates and days available to our clients. *Therapy does not take place year round.*

How to apply:

- Fill out the attached application and mail, fax, or email it into our clinic. Be sure to include any recent and relevant paperwork from current and/or past disability services. The more information we have, the better we can serve you.
- To schedule an evaluation if needed, someone from our clinic will contact you once we receive the application. The vast majority of our clients will need to have an evaluation at our center, although some clients are referred straight to the waiting pool for therapy. *Assessment in our clinic does not guarantee recommendation for services in our clinic.*
- After the evaluation, if therapy is recommended, the client is sent to our waiting pool for the following semester. Selections from the waiting pool are multi-factorial, including supervisor expertise, clinical education needs, client groupings, academic scheduling, and enrollment needs. Clients are encouraged to be as flexible as possible with their schedules to increase the likelihood of clinic placement.

Again, thank you for your interest in our center. We look forward to serving you and your family soon.

Sincerely,

Carlin Graveline, M.S., CCC-SLP
Clinic Director
Kay Armstead Center for Communication Disorders
San Jose State University
One Washington Square
San Jose, CA 95192-0079

SAN JOSÉ STATE UNIVERSITY

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COUNCIL ON ACADEMIC ACCREDITATION
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CHILD SPEECH & LANGUAGE EVALUATION APPLICATION (4 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 MM / DD / YYYY

Date of Birth: _____ Place of Birth: _____ Age: _____ Gender: Please Select
MM / DD / YYYY COUNTRY, CITY, STATE

Address: _____
STREET NUMBER & NAME CITY STATE ZIP

What languages does the child speak? _____

Presenting Problem (Why is an evaluation being requested?)

FAMILY INFORMATION

FATHER: _____ Father lives with child? ☐Yes ☐No Occupation: _____
LAST NAME, FIRST NAME M.I.

Address: _____
STREET NUMBER & NAME ***(IF DIFFERENT FROM ABOVE)*** CITY STATE ZIP

Home #: (_____) _____ - _____ Mobile #: (_____) _____ - _____ Work #: (_____) _____ - _____
E-mail: _____ Years of School Completed: _____

MOTHER: _____ Mother lives with child? ☐Yes ☐No Occupation: _____
LAST NAME, FIRST NAME M.I.

Address: _____
STREET NUMBER & NAME ***(IF DIFFERENT FROM ABOVE)*** CITY STATE ZIP

Home #: (_____) _____ - _____ Mobile #: (_____) _____ - _____ Work #: (_____) _____ - _____
E-mail: _____ Years of School Completed: _____

SIBLINGS How many siblings does the applicant have? _____
Please list the full name, date of birth, and brief speech/hearing history for each sibling in the space provided below.

Name: _____ DOB: _____ Speech/Hearing difficulties? Explain: _____
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Name: _____ DOB: _____ Speech/Hearing difficulties? Explain: _____

Which siblings live in the home? _____

EDUCATIONAL & SOCIAL HISTORY

Name of Current School and/or Daycare: _____ Grade: _____
Language(s) spoken at school/daycare: _____ Language(s) spoken at home: _____
Have teachers mentioned concerns regarding speech/language, educational or social skills? If so, please explain:

Does the child receive any special services at school? If so, which type and how often?

How does the child behave at school? If applicable, please list any difficulties with certain subjects.

In any setting, how does the child behave when socializing with other children?

BIRTH HISTORY

The pregnancy was ☐ Full Term ☐ Premature
Were there any complications during pregnancy or child birth? ☐ Yes ☐ No If yes, please explain below:

DEVEOPMENTAL HISTORY

At what age did the child master the skills listed below? Please be as specific as possible.

Sat without support:	0 Years	0 Months	Said sentences of 3+ words:	0 Years	0 Months
Walked without help:	0 Years	0 Months	Followed 1-step directions:	0 Years	0 Months
Began to say single words:	0 Years	0 Months	Followed 2-step directions:	0 Years	0 Months
Put two words together:	0 Years	0 Months	Told a story with 3+ parts:	0 Years	0 Months

Approximately how many words are in your child's vocabulary? _____
Does your child understand what you say without gestures or visuals? ☐ Yes ☐ No Please explain below.

SPEECH AND LANGUAGE HISTORY

At what age did you notice a communication issue with your child? _____

Have other people or family members noticed the issue as well? ☐ Yes ☐ No If yes, please explain below:

How does the child react to his or her communication issue? Please explain below.

Has the child been evaluated by a Speech and Language Pathologist? ☐ Yes ☐ No If yes, please explain:
Full Name of therapist: _____
Location(s): _____
What recommendations did he or she give? Please explain below:

Has the child received speech and language services? ☐ Yes ☐ No If yes, please explain:
Full Name of therapist: _____
Location(s):_____
What recommendations did he or she give? Please explain below:

In the space provided below, please provide any additional information and/or concerns regarding the child's speech, language or hearing problem.

CLIENT REFERENCE INFORMATION

Who referred you to the KACCD clinic? _____
Name of the person filling out this form? _____ Relation to client: _____
What language(s) do you speak? _____
What is your primary language? _____ Secondary language? _____

If applicable, what percent of the day is the primary language spoken by the client? ☐ n/a or 0% (please select)

If applicable, what percent of the day is the secondary language spoken by the client? ☐ n/a or 0% (please select)

MEDICAL HISTORY

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

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

_____

HOSPITAL ADDRESS CITY STATE ZIP

Has the child had any surgeries? ☐ Yes ☐ No (If yes, please list each surgery and explain the reason for the surgery below.)

In the space below, please describe any injuries, traumas, or hospitalizations the child has experienced.

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

Child suffers from: ☐ epileptic seizures ☐ convulsions ☐ frequent fainting ☐ other: _____ ☐ n/a

Does the child have normal hearing? ☐ Yes ☐ No (If no, please explain below.)

Has the child had a hearing evaluation? ☐ Yes ☐ No If yes, please provide the date, location, and findings and recommendations in the space provided below.

Has the child ever had ear infections? ☐ Yes ☐ No If yes, how frequently? _____

How severe were the ear infections? _____

Does the child have allergies? ☐ Yes ☐ No If yes, please list the allergies below.

Please indicate which devices the child uses:

☐ Glasses ☐ Hearing Aids ☐ Braces ☐ Other(s): _____ ☐ n/a

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 processed.