**CLIENT CONTACT FORM**

KACCD-SAN JOSE STATE UNIVERSITY

DEPARTMENT OF COMMUNICATION SCIENCES AND DISORDERS

**PLEASE PRINT LEGIBLY**

Client Name: ___________________________________ Date:__________________________

Date of Birth: ___________________________________ Chron. Age_______☐ Male ☐ Female

Caregiver (if applicable) ___________________________________________________________

Relationship of Caregiver to Client: __________________________________________________

Email: __________________________________________________________________________

Home Phone: ___________________________ Work Phone: _____________________________

Cell Phone: _____________________________ Other Phone: _____________________________

Address: ________________________________________________________________________

_________________________________________________________________________________

Other Contact Information: ________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Emergency Contact Name: _________________________________________________________

Phone (s): _______________________________________________________________________

**Current Status:**

Diagnostic Client ☐

Aural Rehab Client ☐

Speech/ Language Therapy Client ☐

Waiting List for Speech/ Language Therapy ☐

Schedule/Availability: ____________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________