SJSU SAN JOSÉ STATE UNIVERSITY
Communication Disorders and Sciences
Connie L. Lurie college of Education
San José State University
One Washington Square
San José, CA 95192-0064
Kay Armstead Center Speech Clinic 408-924-3679
armstead-center@sjsu.edu

Dear Prospective Client/Family,

Thank you for your interest in the Kay Armstead Center for Communicative Disorders (KACCD). KACCD is a non-profit community clinic that has been serving the needs of individuals of all ages, demonstrating a wide variety of speech, language and hearing difficulties and differences, for over fifty years. The mission of the center is to provide excellent support and services for our clients while enhancing the training of our speech-language pathology student clinicians. KACCD provides services for speech articulation, language delays and disorders, aphasia, brain injury rehabilitation, social pragmatics, fluency/stuttering, accent modification, voice disorders, transgender voice therapy, augmentative and alternative communication (AAC), hearing, and more.

KACCD is a training facility for students enrolled in the Communicative Disorders and Science Program. Supervision is provided at all times by fully licensed and certified clinicians with extensive experience. Clinics operate as coursework for students and therefore follow the San Jose State University semester schedule. Sessions are not offered year round. Applications for assessments are processed throughout each semester as spaces are available. Applications and invitations for treatment clinics are offered at the beginning of each semester only.

How to apply:

1.Fill out the attached application and mail, fax, or email it to our clinic. Include any reports from previous services so that we can better serve you.
2.Someone will contact you when a spot becomes available. Most clients will require a comprehensive evaluation at KACCD prior to receiving an invitation to treatment clinics. At the discretion of the Clinic Director, exceptions to the assessment requirement are made for clients whom provide a comprehensive evaluation report from another provider.
3.Following an assessment with a recommendation for therapy, invitations to treatment services are not guaranteed. Treatment invitations are based on a variety of factors including supervisor expertise, clinical education needs, client groupings, academic scheduling, and enrollment needs.

The Kay Armstead Center for Communicative Disorders (KACCD) is committed to the principle of equal opportunity. The University, College, Department and KACCD do not discriminate in the delivery of professional services or the conduct of research and scholarly activity based on age, citizenship, disability, ethnicity, gender-identity, genetic information, marital status, national origin, physical characteristics, race, religion, sex, sexual orientation, and veteran status.
Again, thank you for your interest in our center. We look forward to serving you and your family soon.

SJSU
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One Washington Square · San José, CA 95192-0079
· Clinic (408) 924-3679 · Fax: (408) 924-3641
Web: www.sjsu.edu/cds/clinic · E-mail: armstead-center@sjsu.edu

Council on Academic Accreditation ACCREDITED | Speech-Language Pathology

CHILD SPEECH & LANGUAGE EVALUATION APPLICATION

Date Received: _____

Please attach any previous reports from school, therapists, or doctors.

CLIENT INFORMATION:

NAME: _____ Date of Birth: _____ Age: _____
last first middle initial month/day/year

Gender: _____ Place of Birth: _____
country, city, state

Primary Language: _____
Languages spoken at home: _____

Address: _____
street

Preferred Phone: _____
Other Phone: _____

_____
city state zip

Who referred you? _____ Date of Application: _____

What is the reason for the referral/evaluation? _____

Name of person completing application: _____ relation to client: _____

FAMILY INFORMATION:

MOTHER: _____ Lives with child: yes no primary language: _____
last first
highest grade or degree completed: _____

Address: _____
(if different from above) street

Preferred Phone: _____
Other Phone: _____
E-mail: _____

_____
city state zip

FATHER: _____ Lives with child: yes no primary language: _____
last first
highest grade or degree completed: _____

Address: _____
(if different from above) street

Preferred Phone: _____
Other Phone: _____
E-mail: _____

_____
city state zip

SIBLINGS:

Name	Date of Birth	Speech/Hearing Disabilities? (Explain)	Lives with client

EDUCATIONAL & SOCIAL HISTORY

Name of current school/daycar _____ Grade: _____

Language(s) spoken at school/daycare: _____

Have teachers mentioned concerns regarding speech, language, social skills, or education? If so, please explain:

Does the child receive special services at home or school? If so, which type and how often? (Please provide copy o

How does the child behave at school? Please describe if there are difficulties with specific subjects.

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

BIRTH HISTORY

Delivered: premature full term

Describe any complications during pregnancy or child birth.

DEVELOPMENTAL HISTORY

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

Sat without support: _____ Said sentences of 3+ words: _____ Primary language: _____

Walked without support: _____ Followed 1-step directions: _____ Spoken_____% of the day

Began to say single words: _____ Followed 2-step directions: _____

Put two words together: _____ Told a story with 3+ parts: _____

2nd language: _____

Spoken_____% of the day

Approximately how many words are in your child's vocabulary?_____

Does your child understand what you say without gestures? yes no

At what age did you notice a communication issue with your ch_____

DEVELOPMENTAL HISTORY (continued)

Have other people or family members noticed the issue as wel yes no If yes, please explain.

Please provide any additional information and/or concerns regarding the child's development including speech, language, hearing, attention, and/or motor development.

MEDICAL HISTORY

Pediatrician or Docto _____ Phone: _____

Hospital/Facility: _____ Phone: _____

Please describe any injuries, traumas, or hospitalizations the child has experienced.

Has the child had any surgeries yes no If yes, please list and provide the date and reason.

Does the child have any chronic illnesses (seizures, convulsions, fainting, asthma, allergies, etc.). Please list and des

Has the child had a hearing evaluation? yes no Date: _____ Location: _____

Does the child have a hearing loss? yes no Describe the findings and recommendations of the evaluation.

Does the child have a history of ear infections? yes no How many? _____ How frequently? _____

Does the child take any medications? yes no Please list each medication and the reason for taking below.

Please indicate which devices the child us Glasses Hearing aids Braces/Retainer Other:

SERVICE HISTORY

Has the child been evaluated by a speech and language pathol(yes no (Please provide a copy of the report)

Name of therapist: _____ Location: _____

What recommendations were given? Please explain below.

Has the child received speech and language services yes no (Please provide a recent report)

What recommendations and goals were given? Please explain below.

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

Is there anything else you would like us to know?

SO THAT WE CAN BETTER SERVE YOU PLEASE BE SURE TO ATTACH ANY OF THE RECENT REPORST SUCH AS:

Doctor summaries	Speech Reports
Individual Family Service Plan (IFSP)	Occupational Therapy Reports
Individual Education Plan (IEP)	ABA reports

CONTACT PERMISSIONS

_____ I do NOT consent to having specific information (identification, in regards to therapy/assessment, time

_____ (initial) and date of appointment) relayed in voicemail, text or e-mail.

_____ (initial) I give permission to leave messages with specific information (identification, in regards to therapy/assessment, time and date of appointment) in the following methods:

Preferred Phone: _____ Other Phone: _____

Email: _____

CLIENT QUESTIONNAIRE (continued)

How does this problem handicap you in everyday life?

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

MEDICAL HISTORY

Doctor name: _____ Phone: _____

Hospital/Facility: _____ Phone: _____

Please list and describe any injuries, traumas, surgeries or hospitalizations you have experienced.

Do you have any chronic illnesses (seizures, convulsions, fainting, asthma, allergies, etc.). Please list and describe.

Please list current medications and the reason for taking each.

Have you had a hearing evaluation? ☐yes ☐no Date: _____ Location: _____

Do you have normal hearing? ☐yes ☐no Describe the findings and recommendations of the evaluation.

Have other's suggested that you do not hear normally? ☐yes ☐no Please explain.

Please indicate which devices you use: ☐Glasses ☐Hearing aids ☐ Walker ☐Orthodontics

Other: _____