SAN JOSÉ STATE UNIVERSITY

Kay Armstead Center for Communication Disorders
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COUNCIL ON ACADEMIC ACCREDITATION IN AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

ADULT APPLICATION FOR ACCENT MODIFICATION SERVICES (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 are accent modification services 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? _____ %
If applicable, what percent of the day is your secondary language spoken? _____ %

CLIENT QUESTIONNAIRE

What country do you come from? _____
Did you study American English before coming to this country? YES☐ NO☐
How were you taught English?

For how many years have you studied English? _____ For how many years have you spoken English? _____

In an average day, how many hours do you speak your native language? _____

In an average day, how many hours do you speak English? _____

In an average day, how many hours do you speak another language? _____

CLIENT QUESTIONNAIRE (CONT.)

As a child, did you have any problems in learning, speaking, or writing your native language? If so please explain.

Please provide additional information that you would like us to have.

MEDICAL HISTORY

Have you had any significant illnesses, accidents or surgeries? ☐ Yes ☐ No
If yes, please include detailed explanations and dates of all hospitalizations, injuries, and trauma, etc.

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)

If applicable, please explain:

Please rate these speaking situations by difficulty (opportunities where you speak English):

1 – no difficulty **2** -- minimal difficulty **3** - moderate amount of difficulty

4 - significant difficulty **5** - I can't communicate in this situation **N/A** – no opportunity to speak English

Conversations with friends	_____	small group discussion	_____
Asking Questions	_____	talking on the phone	_____
Responding to Questions	_____	classroom teaching	_____
Presenting a prepared speech	_____	other _____	_____

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 processed.