SJSU SAN JOSÉ STATE UNIVERSITY

Connie L. Lurie College of Education
Communicative Disorders and Sciences
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COUNCIL ON ACADEMIC ACCREDITATION
ACCREDITED | SPEECH-LANGUAGE PATHOLOGY

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.

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One Washington Square · San José, CA 95192-0079 · Main: (408) 924-3679 · Fax: (408) 924-3641

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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 MONTH / DAY / YEAR

Date of Birth: _____ Place of Birth: _____ Age: _____ Gender: _____
MONTH / DAY / YEAR CITY, STATE, COUNTRY 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 when available spots open up.