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 José 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 who 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.
ADULT SPEECH & LANGUAGE EVALUATION APPLICATION

Please complete the application and then mail, fax, e-mail or deliver to KACCD. Date Received: 

Please attach any previous reports from 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: ________________ Other Languages: __________________________

Address: ____________________________ Preferred Phone: __________

street

Other Phone: __________

city state zip

E-mail: ____________________________

Who referred you? __________________________ Date of Application: ________________

What is the reason for the referral/evaluation? __________________________

Name of person completing application: __________________________ relation to client: ________

CLIENT QUESTIONNAIRE

What do you feel is the problem with your speech, language, voice, fluency, swallowing, thinking, and/or hearing skills?

________________________________________________________________________

What do you feel has caused the problem(s)?

________________________________________________________________________

When did you first notice the problem?

________________________________________________________________________
What are some situations that make the problem worse? (Example: during confrontations, at restaurants, etc.). Please be specific.

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: __________________________

SERVICE HISTORY

Have you been evaluated by a speech and language pathologist yes  no  (Please provide a copy of the report)
Name of therapist: __________________________ Location: __________________________
What recommendations were given? Please explain below.

Have you 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 your speech, language, communication or hearing.

Is there anything else you would like us to know?

SO THAT WE CAN BETTER SERVE YOU PLEASE BE SURE TO ATTACH ANY RECENT REPORTS SUCH AS:
- Doctor summaries
- Speech reports
- Rehab reports
CONTACT PERMISSIONS

I do NOT consent to having specific information (identification, in regards to therapy/assessment, time and date of appointment) relayed in voicemail, text or e-mail.

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: __________________________