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.

Kay Armstead Center for Communicative Disorders
Dept. of Communicative Disorders and Sciences · Connie L. Lurie College of Education
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

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: _____ Primary Language: _____
country, city, state
Other Languages: _____

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

CLIENT QUESTIONNAIRE

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

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 spe

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 normal 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 pathologis 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 REPORST 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.
(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:
(initial)

Preferred Phone: _____ Other Phone: _____

Email: _____