

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.



**Kay Armstead Center for Communicative Disorders**

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## 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: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
country, city, state Languages spoken at home: \_\_\_\_\_

Address: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_  
street 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:

PARENT: \_\_\_\_\_ Lives with child yes no primary language: \_\_\_\_\_  
last first highest grade or degree completed: \_\_\_\_\_

Address: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_  
(if different from above) street Other Phone: \_\_\_\_\_

city state zip

E-mail: \_\_\_\_\_

PARENT: \_\_\_\_\_ Lives with child yes no primary language: \_\_\_\_\_  
last first highest grade or degree completed: \_\_\_\_\_

Address: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_  
(if different from above) street Other Phone: \_\_\_\_\_

city state zip

E-mail: \_\_\_\_\_

| SIBLINGS: | Name | Date of Birth | Speech/Hearing Disabilities? (Explain) | Lives with client |
|-----------|------|---------------|--|-------------------|
|           |      |               |  |                   |
|           |      |               |  |                   |
|           |      |               |  |                   |
|           |      |               |  |                   |
|           |      |               |  |                   |

**EDUCATIONAL & SOCIAL HISTORY**

Name of current school/daycare: \_\_\_\_\_ 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 child? \_\_\_\_\_

**DEVELOPMENTAL HISTORY (continued)**

Have other people or family members noticed the issue as well? 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 Doctor: \_\_\_\_\_

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 describe.

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 REPORTS 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.

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

Preferred Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
Email: \_\_\_\_\_