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.
CHILD SPEECH & LANGUAGE EVALUATION APPLICATION

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? __________________________

Who referred you? __________________________

Date of Application: __________________________

What is the reason for the referral/evaluation? __________________________

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

FAMILY INFORMATION:

MOTHER: ____________________________ Lives with child __________
  yes  no  primary language: ________________
  highest grade or degree completed: ______

Address: ____________________________ Preferred Phone: __________________________
  (if different from above)
  street

Other Phone: __________________________
  city  state  zip

E-mail: __________________________

FATHER: ____________________________ Lives with child __________
  yes  no  primary language: ________________
  highest grade or degree completed: ______

Address: ____________________________ Preferred Phone: __________________________
  (if different from above)
  street

Other Phone: __________________________
  city  state  zip

E-mail: __________________________
SIBLINGS:

<table>
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<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Speech/Hearing Disabilities? (Explain)</th>
<th>Lives with client</th>
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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 ch _______
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 uses: Glasses  Hearing aids  Braces/Retainer  Other:

SERVICE HISTORY

Has the child 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.

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
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: __________________________
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: ___________________________